Australian Government Department of Health

Medicare Benefits Schedule Book Category 3 Operating from 1 July 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 <u>http://www.health.gov.au/mbsonline</u>

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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</u> request to substantiate that a patient attended a service. There is also a <u>Health Practitioner Guideline for</u> substantiating that a specific treatment was performed. These guidelines are located on the DHS website.

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

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

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

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

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

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

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

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

#### **Non-medical practitioners**

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

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

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

# **GN.2.5 Provider Numbers**

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

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

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

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

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

# GN.2.6 Locum tenens

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

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

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

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

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

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

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

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

Ten year moratorium

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

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

Exclusions - Practitioners who before 1 January 1997 had

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

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

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

# **GN.2.8 Contact details for 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:**

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

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

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

# **GN.4.13 General Practice**

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

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

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

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

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

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

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

#### Vocational recognition of general practitioners

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

(a) certification by the RACGP that the practitioner

- $\cdot$  is a Fellow of the RACGP; and
- · practice is, or will be within 28 days, predominantly in general practice; and

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

(b) certification by the General Practice Recognition Eligibility Committee (GPREC) that the practitioner

 $\cdot$  is a Fellow of the RACGP; and

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

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

(c) certification by ACRRM that the practitioner

 $\cdot$  is a Fellow of ACRRM; and

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

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

Further information on eligibility for recognition should be directed to:

QI&CPD Program Administrator, RACGP

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

Secretary, General Practice Recognition Eligibility Committee:

Email at gprec@health.gov.au

Executive Assistant, ACRRM:

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

#### How to apply for vocational recognition

Medical practitioners seeking vocational recognition should apply to the Department of Human Services using the approved Application Form available on the the Department of Human Services website: <u>www.humanservices.gov.au</u>. 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:

 $\cdot$  is registered as a specialist under State or Territory law; or

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

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

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

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

#### Bulk billing

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

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

Where the patient is bulk billed, an additional charge can **only** be raised against the patient by the practitioner where the patient is provided with a vaccine or vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items **3 to 96**, **179 to 212**, **733 to 789** and **5000 to 5267** (inclusive) and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

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

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

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

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

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

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

Following a review, the Director must:

decide to take no further action; or

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

refer the matter to a PSR Committee.

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

The Committee is authorized to:

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

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

require the production of documents (including clinical notes).

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

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

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

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

an unusual occurrence;

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

the characteristics of the patients.

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

(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 x 80% = \$32. However, as the EMSN benefit cap is \$30, only \$30 will be paid.

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

# GN.11.28 Services not listed in the MBS

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

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

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

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

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

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

The 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</u> <u>specific treatment was performed</u> which is located on the DHS website.

# **CATEGORY 3: THERAPEUTIC PROCEDURES**

# SUMMARY OF CHANGES FROM 01/07/2021

The 01/07/2021 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:

	(a)	new item			New							
	(b)	amended	descriptio	n	Amend							
		fee amend			Fee							
		item num		ed		Renum						
	(e)	EMSN ch	anged			EMSN						
<b>.</b>	Deleted Items											
30096	30111	30114	30373	30375	30376	30378	30379	30391	30393	30394	30402	30403
30405	30434	30436	30437	30438	30446	30466	30467	30496	30497	30499	30500	30502
30503	30505	30506	30508	30509	30523	30524	30527	30535	30536	30538	30539	30541
30542	30544	30545	30547	30548	30550	30551	30553	30554	30556	30557	30564	30566
30568	30569	30571	30572	30575	30578	30580	30581	30586	30587	30597	30602	30603
30605	30609	30614	31420	31450	31452	31464	31470	38215	38218	38220	38222	38225
38228	38231	38234	38237	38240	38243	38246	38300	38303	38306	38312	38315	38318
38371	38384	38387	38390	38393	38470	38473	38475	38478	38480	38481	38483	38488
38489	38496	38497	38498	38500	38501	38503	38504	38505	38506	38507	38559	38562
38565	38577	38588	38613	38640	38647	38650	38654	38712	38763	43500	43503	43506
43509	43512	43515	43518	43524	46306	46307	46327	46366	46369	46396	46402	46405
46429	46435	46447	46459	46462	46494	46516	47006	47036	47039	47048	47051	47072
47378	47492	47504	47507	47510	47513	47522	47525	47564	47567	47576	47594	47606
47609	47627	47633	47636	47642	47645	47651	47654	47726	47729	47732	47912	47920
47930	47933	47936	47948	47951	47957	47963	47966	47969	47972	48200	48203	48206
48209	48212	48215	48218	48221	48224	48227	48230	48233	48236	48239	48242	48418
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49561	49562	49563	49566	49700	49721	49842	49848	49863	50100	50102	50103	50104
50106	50109	50121	50127	50227	50230	50315	50318	50327	50342	50349	50353	50363
50366	50387	50402	50405	50408	50500	50504	50516	50520	50650	50658		
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New It									a			
30648	30651	30652	30655	30657	30720	30721	30722	30723	30724	30725	30730	30731
30732	30750	30751	30752	30753	30754	30755	30756	30760	30761	30762	30763	30770
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38322	38323	38461	38463	38467	38471	38472	38474	38484	38499	38502	38510	38511
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31435	31438						31466					
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49304 49800	49369 49803		49708 49809							49724 49830		
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51306	51315	51318	91850	91851	91852	91853	91855	91856	91857	91858		

## Indexation

Indexation was applied to most of the general medical services items, all diagnostic imaging services (except nuclear medicine imaging and magnetic resonance imaging services) and two pathology items (74990 and 74991). The MBS indexation factor for 1 July 2021 is 0.9 per cent.

Further information on the indexation schedule for the MBS is available on the Medicare Indexation Schedule page.

#### **General Surgery**

MBS items for general surgery services are changing to reflect contemporary practice, incentivise best clinical practice, combine like procedures, and clarify the requirements of ambiguous services to simplify the arrangements for doctors and patients.

The changes will introduce 35 new items, amend 50 items and delete 73 items relating to laparoscopies and laparotomies, small bowel resections, abdominal wall hernia repairs, oncology and bariatric services, surgical excisions, and procedures relating to the oesophageal, stomach, liver, biliary, pancreas, spleen and lymph nodes.

These changes are a result of the Government's response to the MBS Review Taskforce recommendations and consultation with stakeholders. These changes are relevant for surgeons involved in the performance and claiming of general surgery services; patients; private health insurers; and private hospitals. Further information is available on the General Surgery Services Changes factsheet page.

#### **Orthopaedic Surgery**

MBS items for orthopaedic surgery services are changing to ensure services are clinically appropriate, reflect contemporary clinical practice and improve quality of care and safety for patients. The changes include:

·168 new items.

 $\cdot$ 280 amended items for services considered as requiring change in order to improve clarity of services for patients and providers, and improve the MBS to better reflect contemporary clinical practice.

·137 superseded items where services have been consolidated into new or amended items.

•9 deleted items for services considered to be obsolete or no longer reflective of contemporary best practice.

These changes are a result of the MBS Review Taskforce recommendations and extensive consultation with stakeholders. These changes are relevant for all specialists involved in the provision of orthopaedic services, consumers claiming these services, private hospitals and private health insurers. Further information is available on the Changes to MBS Items for Orthopaedic Surgery Services factsheet page.

## Transcatheter Mitral Valve Replacement – Mitraclip

On 1 July 2021, the Australian Government will introduce four new items for the provision of transcatheter mitral valve repair (TMVr) using the MitraClip<sup>™</sup> implant for managing severe mitral valve regurgitation. Mitral valve regurgitation occurs when the heart's mitral valve doesn't close tightly and blood flows backward in the heart.

Eligible patients, who are ineligible for open surgical management with moderate-severe mitral valve regurgitation will be able to receive a Medicare rebate for this less invasive approach through transcatheter repair using the MitraClip<sup>TM</sup> implant.

#### **Cardiac Services**

The Australian Government is making changes to modernise cardiac surgical services to ensure they reflect current medical practice, support high-value care and ensure patients receive procedures in line with best practice. These changes follow recommendations from the MBS Review Taskforce.

The range of changes to cardiac surgical services include updates to item descriptors, combining similar surgical procedures, introducing items that represent a complete medical service, incentivising advanced techniques, removal of procedures that no longer represent best practice, and reducing low value angiography and coronary artery stenting by aligning the items with appropriate use criteria.

From 1 July 2021, there will also be some minor changes to existing cardiac imaging services to align co-claiming restrictions with other cardiac services, better reflect the policy intent of the services and better align these services with clinical guidelines.

Further information is available on the Modernising Cardiac Surgical Services factsheet page.

## 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 <a href="https://pathways.nice.org.uk/pathways/psoriasis">https://pathways/psoriasis</a>

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

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

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

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

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:

## 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 (<u>www.mbsonline.gov.au/telehealth</u>).

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	<b>Existing Items</b> face to face	<b>Telehealth Items</b> - video conference	<b>Telephone items</b> - 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:			
<ul> <li>(i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or</li> <li>(ii) an obstetrician; or</li> </ul>	16408	91852	91857
(iii) a general practitioner			
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> <u>COVID-19 fact sheets.</u>

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 <u>'Provider Frequently Asked Questions' at MBSonline.gov.au</u>.

#### **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 <u>Australian Cyber Security Centre website</u>.

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

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

- · Major cardiac problems e.g cardiomyopathy, unstable ischaemic heart disease, heart failure
- · Major respiratory disease e.g COPD, respiratory failure, acute lung conditions eg. infection and asthma,

 $\cdot$  Major neurological conditions - CVA, intra/extra cerebral haemorrhage, cerebral palsy and/or major intellectual disability, degenerative conditions of the CNS

· Major metabolic conditions - e.g unstable diabetes, uncontrolled hyperthyroidism, renal failure, liver failure, immune deficiency

 $\cdot$  Anaesthetic problems - eg past history of awareness, known or anticipated difficulty with securing the airway, malignant hyperpyrexia, drug allergy,

- $\cdot$  Other conditions -
- patients with history of stroke/TIA's presenting for vascular surgery

- patients on anti-platelet agents presenting for major surgery requiring management of anticoagulant status

- patients with poor respiratory/cardiac function presenting for major surgery requiring management of perioperative medications, analgaesia and monitoring

## NOTE I:

It is important to note that:

 $\cdot$  patients undergoing the types of advanced surgery listed above but who are otherwise of reasonable health and who, therefore, do not require a longer pre-anaesthesia consultation as provided for under items 17615-17625, would qualify for benefits under item 17610; and

• not all patients with complex medical problems will qualify for a longer consultation under items 17615-17625. For example, patients who have reasonably stable diabetes may only require a short consultation, covered under item 17610. Similarly, patients with reasonably well controlled emphysema (COPD) undergoing minor surgery may only require a short pre-anaesthesia consultation (item 17610), whereas the same patient scheduled for an upper abdominal laparotomy and with recent onset angina with the possible need for ICU postoperatively may require a longer consultation.

## NOTE II:

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

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

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

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

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

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

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

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

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

#### NOTE :

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

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

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

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

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

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

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

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

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

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

#### **TN.6.4 Telehealth Specialist Services**

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

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

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

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

### Clinical indications

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

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

#### Restrictions

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

#### **Billing Requirements**

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

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

#### Eligible Geographical Areas

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

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

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

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

## Record Keeping

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

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

### Extended Medicare Safety Net (EMSN)

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

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

#### Aftercare Rule

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

#### Multiple attendances on the same day

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

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

#### Referrals

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

#### Technical requirements

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

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

## TN.7.1 Regional or Field Nerve Blocks - General

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

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

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

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

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

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

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

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

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

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

This items covers caudal infusion/injection.

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

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

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

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

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

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

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

## **TN.8.1 Surgical Operations**

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

• "as an independent procedure";

· "not being a service associated with a service to which another item in this Group applies"; or

· "not being a service to which another item in this Group applies"

An explanation of each of these phrases is as follows.

## As an Independent Procedure

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

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

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

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

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

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

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

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

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

# **TN.8.2 Multiple Operation Rule**

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

- 100% for the item with the greatest Schedule fee

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

plus 25% for each other item.

## Note:

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

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

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

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

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

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

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

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

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

#### Extended Medicare Safety Net Cap

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

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

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

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

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

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

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

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

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

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

### **Private Patients**

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

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

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

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

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

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

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

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

#### **Public Patients**

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

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

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

## **Fractures**

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

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

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

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
ddle phalanx of finger 6	
ne or more metacarpals not involving base of first carpometacarpal joint 6	
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.

Guidelines are available on the Department of Health website for what <u>health practitioners can do to substantiate</u> <u>proof of malignancy</u> where required for MBS items.

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

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

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

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

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

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

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

Anatomically, the dissection extends from below upwards as follows:

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

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

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

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

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

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

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

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

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

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

#### Cleaning, disinfection and sterilisation procedures

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

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

#### Anaesthetic and resuscitation equipment

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

#### **Conjoint Committee**

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

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

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

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

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

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

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

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

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

FNA is indicated for patients with a suspected breast abscess or a symptomatic simple breast cyst.

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  $40 \text{kg/m}^2$  or more, or a patient with a BMI of  $35 \text{kg/m}^2$  or more with other major medical co-morbidities (such as diabetes, cardiovascular disease, cancer). The BMI values in different population groups may vary due, in part, to different body proportions which affect the percentage of body fat and body fat distribution. Consequently, different ethnic groups may experience major health risks at a BMI that is below the 35-40 kg/m<sup>2</sup> provided for in the definition. The decision to undertake obesity surgery remains a matter for the clinical judgment of the surgeon.

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

Practitioners providing items 31569, 31572, 31575 and 31581 should be registered with and provide relevant data to the Bariatric Surgery Registry.

## 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<sup>®</sup>) laser therapy.

#### TN.8.92 Escharotomy - (Item 45054)

Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

#### TN.8.93 Local Skin Flap - Definition

Medicare benefits for flaps are only payable when clinically appropriate. Clinically appropriate in this instance means that the flap or graft is required to close the defect because the defect cannot be closed directly, or because the flap is required to adapt scar position optimally with regard to skin creases or landmarks, maintain contour on the face or neck, or prevent distortion of adjacent structures or apertures.

A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Item 45201, claimable once per defect. Additional flaps are to be claimed under Item 45202, if clinically indicated.

Note: refer to 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 discrete 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 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. The administration of oral sedation is not sufficient justification for the use of item 42739, and item 42738 is applicable in those circumstances. 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 the administration of anaesthetic by an anaesthetist 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).

GP anaesthetists are expected to meet the Joint Consultative Committee on Anaesthesia (JCCA) Continuing Professional Development (CPD) Standard which defines the minimum recommended requirements for all general practitioners providing anaesthesia services. Practitioners billing item 42739 must keep clinical notes outlining the basis of the requirement for the administration of anaesthetic by an anaesthetist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## TN.8.126 Flap Repair - (Item 45202)

Practitioners must only perform a muscle or skin flap repair where clinical need can be clearly evidenced (i.e. where a patient hassevere pre-existing scarring, severe skin atrophy, sclerodermoid changes or where the defect is contiguous with a 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 <u>Cancer Council Australia website</u>.

Surveillance colonoscopy should be planned based on high-quality endoscopy in a well-prepared colon using most recent and previous procedure information when histology is known. Clinicians should use their best clinical judgement to determine the interval between testing and the item that best suits the condition of the patient.

The NHMRC guidelines do not support the use of colonoscopy for patients at average or slightly above average risk of colorectal cancer who do not have symptoms or a positive faecal occult blood test (FOBT).

Items 32222-32228 specify that there is endoscopic examination to the caecum. The 'to the caecum' requirements for colonoscopy examinations do not apply to patients who have no caecum following right hemi colectomy. For these patients the examination should be to the anastomosis. Item 32084 should be billed if preparation is inadequate to allow visualisation to the caecum.

General practitioners should ensure colonoscopy referral practices align with applicable national guidelines, including the Royal Australian College of General Practitioners' guidelines for preventive activities in general

practice (<u>the red book</u>). In addition, general practitioners are urged to recommend biennial FOBT screening to ageappropriate 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/1.73m<sup>2</sup> 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, 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.8.167 Breast Prosthesis Removal (Item 45551)

Providers should note that 45551 is intended to be claimed when there is a medical indication for performing capsulectomy, such as capsular contracture, presence of a mass within the capsule (seen on pre-operative imaging or intraoperatively) or evidence of Breast Implant Associated Anaplastic Large Cell Lymphoma or other malignancy. If this item is claimed the capsule must be sent for histopathology.

### 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).

\* **NOTE:** It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.

It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

### Definition of Emergency

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as existing where the patient requires immediate treatment without which there would be significant threat to life or body part.

### **Definition of After Hours**

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies.

#### TN.10.4 Deriving the Schedule Fee under the RVG

The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule is derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	DESCRIPTION	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	012 Central Venous Pressure Monitoring		\$60.30
	TOTAL	34	\$683.40

## After Hours Emergency Services

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x \$20.10)
20840	Anaesthesia for resection of perforated bowel	6	\$120.60
23200	Time - 4 hours 40 minutes	24	\$482.40
25000	Modifier - Physical status	1	\$20.10
22012	Central Venous Pressure Monitoring	3	\$60.30
	TOTAL	34	Schedule fee = \$683.40
25025	Anaesthesia After Hours Emergency Modifier		Schedule Fee \$683.40 x 50% = \$341.70

# **Definition of Radical Surgery for the RVG**

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems. See notes T10.18 and T10.22 which clarify the definitions of the words "extensive" and "radical" used in items 20192 and 20474.

### Multiple Anaesthesia Services

Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE
20790	Anaesthesia for open Cholecystectomy	8	\$160.80
20752	Incisional Hernia	l 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 osteoctomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

### TN.10.22 Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474)

Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

### TN.10.23 Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670)

This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

#### TN.10.24 Anaesthesia for Femoral Artery Embolectomy - (Item 21274)

Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

#### TN.10.25 Anaesthesia for Cardiac Catheterisation - (Item 21941)

Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

# TN.10.26 Anaesthesia for 2 Dimensional Real Time Transoesophageal Echocardiography - (Item 21936)

Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

### TN.10.27 Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and 7)

Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:

- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:

- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;

- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the jejunum, ileum, or colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

# TN.10.28 Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865)

Benefits are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Benefits do not apply for microsurgical rotation flaps or for re-implementation of digits or either the hand or the foot.

# TN.10.29 Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911)

Benefits are not payable under item 20911 for diagnostic ureteroscopy.

# TN.10.30 Credentialing for peri-operative cardiac ultrasound services (22051)

Item 22051 should be performed by a provider who is appropriately credentialed to provide the particular service, by a recognised body for the credentialing of peri-operative cardiac ultrasound services. Credentialing must be based on criteria consistent with those recommended by the Australian and New Zealand College of Anaesthetists in the current version of their Professional Document PS46 "Guidelines on Training and Practice of Perioperative Cardiac Ultrasound in Adults.

# TN.11.1 Botulinum Toxin - (Items 18350 to 18379)

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently three botulinum toxin agents with TGA registration (Botox®, Dysport® and Xeomin®). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is recognised as an eligible medical practitioner for the relevant indication under the arrangements under Section 100 of the *National Health Act 1953* (the Act) relating to the use and supply of botulinum toxin. The specialist qualifications required to administer botulinum toxin vary across the indications for which the medicine is listed on the PBS, and are detailed within the relevant PBS restrictions available at: <a href="https://www.pbs.gov.au/browse/section100">www.pbs.gov.au/browse/section100</a>-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

	CELLANEOUS THERAPEUTIC 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.
<b>Fee</b> 13015	(See para TN.1.1 of explanatory notes to this Category)         Fee: \$265.10       Benefit: 75% = \$198.85       85% = \$225.35
	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
<b>Fee</b> 13020	(See para TN.1.1 of explanatory notes to this Category) <b>Fee:</b> \$269.35 <b>Benefit:</b> 75% = \$202.05 85% = \$228.95
	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)
<b>Fee</b> 13025	(See para TN.1.1 of explanatory notes to this Category) <b>Fee:</b> \$120.35 <b>Benefit:</b> 75% = \$90.30 85% = \$102.30
	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of ar hour)
<b>Fee</b> 13030	(See para TN.1.1 of explanatory notes to this Category)Fee: $\$170.05$ Benefit: $75\% = \$127.55$ $85\% = \$144.55$
	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
<b>Fee</b> 13100	(See para TN.1.2 of explanatory notes to this Category) <b>Fee:</b> \$142.20 <b>Benefit:</b> 75% = \$106.65 85% = \$120.90
<b>Fee</b> 13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance

	CELLANEOUS 1 DURES	HERAPEUTIC		2. DIALYSIS
	time on the pati	ent by the supervising med	lical specialist does not excee	d 45 minutes in 1 day
	(See para TN.1.2 <b>Fee:</b> \$74.10	of explanatory notes to this Ca Benefit: 75% = \$55.60		
	physician in the	practice of his or her speci	ialty of renal medicine, for a	ritoneal dialysis), by a consultant patient with end-stage renal a maximum of 12 claims per
<b>Fee</b> 13104	(See para TN.1.3, <b>Fee:</b> \$153.90	, TN.1.23 of explanatory notes <b>Benefit:</b> 85% = \$130.8		
	Haemodialysis	for a patient with end-stage	e renal disease if:	
			nurse, an Aboriginal health w n behalf of a medical practitic	
	(b) the service i	s supervised by the medica	l practitioner (either in persor	n or remotely); and
	(c) the patient's	care is managed by a neph	rologist; and	
	(d) the patient is remotely); and	s treated or reviewed by the	e nephrologist every 3 to 6 m	onths (either in person or
	(e) the patient is	s not an admitted patient of	a hospital; and	
	(f) the service is	s provided in a Modified M	Ionash 7 area	
<b>Fee</b> 13105	<b>Fee:</b> \$615.95	<b>Benefit:</b> 100% = \$615.		
	DECLOTTING	OF AN ARTERIOVENOU	US SHUNT	
Fee 13106	Fee: \$126.30	<b>Benefit:</b> 75% = \$94.75	5 85% = \$107.40	
		PERITONEAL CATHETI		DR DIALYSIS INSERTION
Fee 13109	Fee: \$236.95	<b>Benefit:</b> 75% = \$177.7	75 85% = \$201.45	
		PERITONEAL CATHETI eter cuffs) (Anaes.)	ER (Tenckhoff or similar) FC	OR DIALYSIS, removal of
Fee 13110	Fee: \$237.75	<b>Benefit:</b> 75% = \$178.3	35 85% = \$202.10	
	CELLANEOUS 1 DURES	HERAPEUTIC	3. ASSISTED	REPRODUCTIVE SERVICES
	Group T1. Misc	cellaneous Therapeutic Pr	rocedures	
		Subgroup 3	3. Assisted Reproductive Serv	vices
<b>Fee</b> 13200	PROCEEDING including quant treatment couns transfer of froze	TO OOCYTE RETRIEVA itative estimation of hormo selling and embryology labo en embryos or donated emb	ones, semen preparation, ultra oratory services but excluding	s to induce superovulation, and sound examinations, all g artificial insemination or hich item 13201, 13202, 13203,

# 3. ASSISTED REPRODUCTIVE SERVICES

	calendar year
	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$3,236.75 <b>Benefit:</b> 75% = \$2427.60 85% = \$3152.05 <b>Extended Medicare Safety Net Cap:</b> \$1,714.20
	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - each cycle SUBSEQUENT to the first in a single calendar year
<b>Fee</b> 13201	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$3,027.65 <b>Benefit:</b> 75% = \$2270.75 85% = \$2942.95 <b>Extended Medicare Safety Net Cap:</b> \$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
<b>Fee</b> 13202	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$484.40 <b>Benefit:</b> 75% = \$363.30 85% = \$411.75 <b>Extended Medicare Safety Net Cap:</b> \$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
<b>Fee</b> 13203	(See para TN.1.4 of explanatory notes to this Category)         Fee: \$506.45       Benefit: 75% = \$379.85       85% = \$430.50         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
<b>Fee</b> 13206	(See para TN.1.4 of explanatory notes to this Category)         Fee: \$484.40       Benefit: 75% = \$363.30       85% = \$411.75         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
<b>Fee</b> 13209	(See para TN.1.4 of explanatory notes to this Category)         Fee: \$88.15       Benefit: 75% = \$66.15       85% = \$74.95         Extended Medicare Safety Net Cap: \$11.15
	Professional attendance on a patient by a specialist practising in his or her specialty if:

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES			
	(a) the attendance is by video conference; and			
	(b) item 13209 applies to the attendance; and			
	(c) the patient is not an admitted patient; and			
	(d) the patient:			
	(i) is located both:			
	(A) within a telehealth eligible area; and			
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or			
	(ii) is a care recipient in a residential care service; or			
	(iii) is a patient of:			
	(A) an Aboriginal Medical Service; or			
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies			
	(See para TN.1.21 of explanatory notes to this Category) <b>Derived Fee:</b> 50% of the fee for item 13209. Benefit: 85% of the derived fee <b>Extended Medicare Safety Net Cap:</b> \$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.)			
<b>Fee</b> 13212	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$368.80 <b>Benefit:</b> 75% = \$276.60 85% = \$313.50 <b>Extended Medicare Safety Net Cap:</b> \$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.)			
<b>Fee</b> 13215	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$115.65 <b>Benefit:</b> 75% = \$86.75 85% = \$98.35 <b>Extended Medicare Safety Net Cap:</b> \$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.)			
<b>Fee</b> 13218	(See para TN.1.4, TN.1.5 of explanatory notes to this Category)         Fee: \$825.70       Benefit: 75% = \$619.30       85% = \$741.00         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			
<b>Fee</b> 13221	(See para TN.1.4 of explanatory notes to this Category) Fee: \$52.80 Benefit: 75% = \$39.60 85% = \$44.90 Extended Medicare Safety Net Cap: \$22.20			

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which Item 13203 or 13218 applies
<b>Fee</b> 13251	(See para TN.1.5 of explanatory notes to this Category)         Fee: \$434.90       Benefit: 75% = \$326.20       85% = \$369.70         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.
<b>Fee</b> 13260	(See para TN.1.22 of explanatory notes to this Category) <b>Fee:</b> \$431.80 <b>Benefit:</b> 75% = \$323.85 85% = \$367.05 <b>Extended Medicare Safety Net Cap:</b> \$280.70
Fee	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required
13290	<b>Fee:</b> \$212.50 <b>Benefit:</b> 75% = \$159.40 85% = \$180.65
Fee	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.)
13292	<b>Fee:</b> \$425.30 <b>Benefit:</b> 75% = \$319.00 85% = \$361.55
	CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATAL
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 4. Paediatric & Neonatal
<b>F</b>	UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate
Fee 13300	<b>Fee:</b> \$59.25 <b>Benefit:</b> 75% = \$44.45 85% = \$50.40
	UMBILICAL ARTERY CATHETERISATION with or without infusion
Fee 13303	<b>Fee:</b> \$87.85 <b>Benefit:</b> 75% = \$65.90 85% = \$74.70
_	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor
Fee 13306	<b>Fee:</b> \$347.65 <b>Benefit:</b> 75% = \$260.75 85% = \$295.55
	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected
Fee 13309	<b>Fee:</b> \$296.40 <b>Benefit:</b> 75% = \$222.30 85% = \$251.95
	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS

T1. MISC PROCEI	CELLANEOUS TH	ERAPEUTIC	4. PAEDIATRIC & NEONATAL
FROCL	Fee: \$29.60	<b>Benefit:</b> 75% = \$22.20 85% = \$25.20	4. FAEDIATRIC & REGNATAL
		CATHETERISATION - by open exposure i	in a patient under 12 years of age (Anaes)
<b>Amend</b> Fee 13318		explanatory notes to this Category) <b>Benefit:</b> $75\% = \$177.50$ $85\% = \$201.20$	in a patient under 12 years of age (Anaes.)
15510		CATHETERISATION in a neonate via peri	pheral vein (Anaes.)
F <b>ee</b> 13319	Fee: \$236.65	<b>Benefit:</b> 75% = \$177.50 85% = \$201.20	1
T1. MISO PROCEI	CELLANEOUS TH	ERAPEUTIC	5. CARDIOVASCULAR
	Group T1. Miscell	aneous Therapeutic Procedures	
		Subgroup 5. Cardiovas	scular
Amend Fee	Restoration of card cardiac surgery (H	iac rhythm by electrical stimulation (cardio (Anaes.)	version), other than in the course of
13400	Fee: \$100.75	<b>Benefit:</b> 75% = \$75.60	
T1. MISO PROCEI	CELLANEOUS TH	ERAPEUTIC	6. GASTROENTEROLOG
	Group T1. Miscell	aneous Therapeutic Procedures	
		Subgroup 6. Gastroente	erology
Fee	GASTRO-OESOP	HAGEAL balloon intubation, for control of	bleeding from gastric oesophageal varice
13506	Fee: \$191.95	<b>Benefit:</b> 75% = \$144.00 85% = \$163.20	
T1. MISO PROCEI	CELLANEOUS TH	ERAPEUTIC	8. HAEMATOLOG
	Group T1. Miscell	aneous Therapeutic Procedures	
		Subgroup 8. Haemato	ology
	HARVESTING O purpose of transpla	F HOMOLOGOUS (including allogeneic) o ntation (Anaes.)	or AUTOLOGOUS bone marrow for the
<b>Fee</b> 13700	Fee: \$346.80	<b>Benefit:</b> 75% = \$260.10 85% = \$294.80	
	Transfusion of blo haemodilution	od, including collection from donor, when u	sed for intra-operative normovolaemic
F <b>ee</b> 13703	Fee: \$124.30	<b>Benefit:</b> 75% = \$93.25 85% = \$105.70	
		OF BLOOD or bone marrow already collected	ed
<b>Fee</b> 13706	(See para TN.1.7 of <b>Fee:</b> \$86.70	Explanatory notes to this Category) Benefit: 75% = \$65.05 85% = \$73.70	
<b>Fee</b> 13750	utilising continuou	AEMAPHERESIS for the removal of plasm s or intermittent flow techniques; including performed; continuous monitoring of vital s	morphological tests for cell counts and

	CELLANEOUS THERAPEUTIC DURES 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		
	<b>Fee:</b> \$142.20 <b>Benefit:</b> 75% = \$106.65 85% = \$120.90		
Fee	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or 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	<b>Fee:</b> \$142.20 <b>Benefit:</b> 75% = \$106.65 85% = \$120.90		
T	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda		
<b>Fee</b> 13757	<b>Fee:</b> \$75.90 <b>Benefit:</b> 75% = \$56.95 85% = \$64.55		
	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		
<b>Fee</b> 13760	(See para TN.1.26 of explanatory notes to this Category) <b>Fee:</b> \$793.50 <b>Benefit:</b> 75% = \$595.15 85% = \$708.80		
	CELLANEOUS THERAPEUTIC9. PROCEDURES ASSOCIATED WITH INTENSIVEDURESCARE 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.)		
<b>Fee</b> 13815	(See para TN.1.6, TN.1.10 of explanatory notes to this Category) <b>Fee:</b> \$118.25 <b>Benefit:</b> 75% = \$88.70 85% = \$100.55		
	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.)		
<b>Fee</b> 13818	(See para TN.1.10 of explanatory notes to this Category)Fee: $$118.30$ Benefit: $75\% = $88.75$ $85\% = $100.60$		
	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid		
Fee	bolt or similar, by a specialist or consultant physician - each day		
13830	Fee: \$78.40         Benefit: 75% = \$58.80         85% = \$66.65		
Fee	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno- arterial cardiopulmonary extracorporeal life support		

# 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: \$917.50       Benefit: 75% = \$688.15       85% = \$832.80         Veno-arterial cardiopulmonary extracorporeal life support, management of—the first day		
<b>Fee</b> 13834	(See para TN.1.10 of explanatory notes to this Category) <b>Fee:</b> \$513.65 <b>Benefit:</b> 75% = \$385.25 85% = \$436.65		
	Veno-arterial cardiopulmonary extracorporeal life support, management of-each day after the first		
<b>Fee</b> 13835	(See para TN.1.10 of explanatory notes to this Category)Fee: $$119.50$ Benefit: $75\% = $89.65$ $85\% = $101.60$		
	Veno-venous pulmonary extracorporeal life support, management of-the first day		
<b>Fee</b> 13837	(See para TN.1.10 of explanatory notes to this Category) <b>Fee:</b> \$513.65 <b>Benefit:</b> 75% = \$385.25 85% = \$436.65		
	Veno-venous pulmonary extracorporeal life support, management of-each day after the first		
<b>Fee</b> 13838	(See para TN.1.10 of explanatory notes to this Category)Fee: $\$119.50$ Benefit: $75\% = \$89.65$ $85\% = \$101.60$		
Ess	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes		
<b>Fee</b> 13839	<b>Fee:</b> \$23.95 <b>Benefit:</b> 75% = \$18.00 85% = \$20.40		
	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno- venous pulmonary extracorporeal life support No separate ultrasound item is payable with this item		
<b>Fee</b> 13840	(See para TN.1.10 of explanatory notes to this Category) <b>Fee:</b> \$614.70 <b>Benefit:</b> 75% = \$461.05 85% = \$530.00		
	Intra-arterial cannulation, including under ultrasound guidance where clinically appropriate, for the purpose of intra-arterial pressure monitoring or arterial blood sampling (or both)		
	No separate ultrasound item is payable with this item		
<b>Fee</b> 13842	(See para TN.1.10 of explanatory notes to this Category)Fee: $\$97.35$ Benefit: $75\% = \$73.05$ $85\% = \$82.75$		
	Counterpulsation by intra-aortic balloon-management including associated consultations and monitoring of parameters by means of full haemodynamic assessment and management on several occasions on a day – each day		
<b>Fee</b> 13848	(See para TN.1.10 of explanatory notes to this Category)Fee: $$162.45$ Benefit: $75\% = $121.85$ $85\% = $138.10$		
	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		
<b>Fee</b> 13851	(See para TN.1.10 of explanatory notes to this Category) <b>Fee:</b> \$513.65 <b>Benefit:</b> 75% = \$385.25 85% = \$436.65		
Fee	Ventricular assist device, management of, for a patient admitted to an intensive care unit, including		

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT	
13854	<ul> <li>management of complications arising from implantation or management of the device - each day af the first day</li> <li>(See para TN.1.10 of explanatory notes to this Category)</li> <li>Fee: \$119.50 Benefit: 75% = \$89.65 85% = \$101.60</li> </ul>		
	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION (other than in the context of an anaesthetic for surgery), outside an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit		
<b>Fee</b> 13857	(See para TN.1.10 of explanatory notes to this Category)Fee: $$152.35$ Benefit: $75\% = $114.30$ $85\% = $129.50$		
	CELLANEOUS THERAPEUTIC DURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT	
	Group T1. Miscellaneous Therapeutic P	rocedures	
	Subgroup 10. Management A	nd Procedures Undertaken In An Intensive Care Unit	
	(Note: See par	a T1.8 of Explanatory Notes to this	
	Category for d	lefinition of an Intensive Care Unit)	
	immediately available and exclusively rost	ive Care Unit by a specialist or consultant physician who is tered for intensive care - including initial and subsequent ing, arterial sampling and bladder catheterisation -	
<b>Fee</b> 13870	(See para TN.1.9, TN.1.11, TN.1.10 of explana <b>Fee:</b> \$376.75 <b>Benefit:</b> 75% = \$282.6		
	immediately available and exclusively rost	ive Care Unit by a specialist or consultant physician who is tered for intensive care - including all attendances, ampling and bladder catheterisation - management on each	
<b>Fee</b> 13873	(See para TN.1.9, TN.1.11 of explanatory notes <b>Fee:</b> \$279.50 <b>Benefit:</b> 75% = \$209.6		
	intracavity pressure, continuous monitorin by a specialist or consultant physician who	onary arterial pressure, systemic arterial pressure or cardiac g by indwelling catheter in an intensive care unit and managed o is immediately available and exclusively rostered for pressure on any calendar day (up to a maximum of 4	
<b>Fee</b> 13876	(See para TN.1.9, TN.1.11, TN.1.10 of explana <b>Fee:</b> \$80.00 <b>Benefit:</b> 75% = \$60.00		
Fee	VENTILATION, in an Intensive Care Uni	OF AND INITIATION OF MECHANICAL it, not in association with any anaesthetic service, by a urpose of subsequent ventilatory support (H)	
13881	(See para TN.1.9 of explanatory notes to this C	'ategory)	

# 10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT

	<b>Fee:</b> \$152.35 <b>Benefit:</b> 75% = \$114.30
	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)
Fee 13882	(See para TN.1.9, TN.1.11 of explanatory notes to this Category) <b>Fee:</b> \$119.90 <b>Benefit:</b> 75% = \$89.95
	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)
<b>Fee</b> 13885	(See para TN.1.9, TN.1.11 of explanatory notes to this Category) <b>Fee:</b> \$159.90 <b>Benefit:</b> 75% = \$119.95
	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)
<b>Fee</b> 13888	(See para TN.1.9, TN.1.11 of explanatory notes to this Category) <b>Fee:</b> \$80.00 <b>Benefit:</b> 75% = \$60.00
	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
<b>Fee</b> 13899	(See para TN.1.11 of explanatory notes to this Category)         Fee: \$278.75       Benefit: 75% = \$209.10       85% = \$236.95         Extended Medicare Safety Net Cap: \$500.00
	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	
<b>Fee</b> 13950 S	(See para TN.1.12, TN.1.27 of explanatory notes to this Category)           Fee: \$112.40         Benefit: 75% = \$84.30         85% = \$95.55	

PROCE	DURES 12. DERMATOLOG		
	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		
<b>Fee</b> 14050	(See para TN.1.14 of explanatory notes to this Category) <b>Fee:</b> \$54.90 <b>Benefit:</b> 75% = \$41.20 85% = \$46.70		
	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.)		
<b>Fee</b> 14100	(See para TN.1.15 of explanatory notes to this Category)Fee: $$158.65$ Benefit: $75\% = $119.00$ $85\% = $134.90$ Extended Medicare Safety Net Cap: $$126.95$		
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment less than 150 cm <sup>2</sup> (Anaes.)		
<b>Fee</b> 14106	(See para TN.1.15 of explanatory notes to this Category) <b>Fee:</b> $$166.65$ <b>Benefit:</b> $75\% = $125.00$ $85\% = $141.70$		
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment 150 cm <sup>2</sup> to 300 cm <sup>2</sup> (Anaes.)		
<b>Fee</b> 14115	(See para TN.1.15 of explanatory notes to this Category) <b>Fee:</b> \$266.90 <b>Benefit:</b> 75% = \$200.20 85% = \$226.90		
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period—area of treatment more than 300 cm <sup>2</sup> (Anaes.)		
<b>Fee</b> 14118	(See para TN.1.15 of explanatory notes to this Category) <b>Fee:</b> \$338.90 <b>Benefit:</b> 75% = \$254.20 85% = \$288.10		
<b>Fee</b> 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 DURES 12. DERMATOLOGY	
	including any associated consultation, if:	
	(a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 to 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and	
	(b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.)	
	(See para TN.1.15 of explanatory notes to this Category)Fee: $$158.65$ Benefit: $75\% = $119.00$ $85\% = $134.90$	
	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDURES	
	Group T1. Miscellaneous Therapeutic Procedures	
	Subgroup 13. Other Therapeutic Procedures	
	POLY-L-LACTIC ACID, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 - once per patient	
<b>Fee</b> 14201	(See para TN.1.16 of explanatory notes to this Category)Fee: $$246.45$ Benefit: $75\% = $184.85$ $85\% = $209.50$ Extended Medicare Safety Net Cap: $$37.00$	
	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	
<b>Fee</b> 14202	(See para TN.1.16 of explanatory notes to this Category)         Fee: \$124.75       Benefit: 75% = \$93.60       85% = \$106.05         Extended Medicare Safety Net Cap: \$18.75	
	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)	
<b>Fee</b> 14203	(See para TN.1.4, TN.1.17 of explanatory notes to this Category) <b>Fee:</b> \$53.20 <b>Benefit:</b> 75% = \$39.90 85% = \$45.25	
	HORMONE OR LIVING TISSUE IMPLANTATION by cannula	
<b>Fee</b> 14206	(See para TN.1.4, TN.1.17 of explanatory notes to this Category) <b>Fee:</b> $\$37.05$ <b>Benefit:</b> $75\% = \$27.80$ $\$5\% = \$31.50$	
	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent	
F <b>ee</b> 14209	<b>Fee:</b> \$92.25 <b>Benefit:</b> 75% = \$69.20 85% = \$78.45	
	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.)	
<b>Fee</b> 14212	<b>Fee:</b> \$192.75 <b>Benefit:</b> 75% = \$144.60 85% = \$163.85	
	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	
<b>Fee</b> 14218	<b>Fee:</b> \$101.90 <b>Benefit:</b> 75% = \$76.45 85% = \$86.65	
Fee	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of,	

	SCELLANEOUS THERAPEUTIC EDURES 13. OTHER THERAPEUTIC PROCEDURE
14221	not being a service associated with a service to which item 13950 applies
	<b>Fee:</b> \$54.65 <b>Benefit:</b> 75% = \$41.00 85% = \$46.50
<b>D</b>	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, includin any electroencephalographic monitoring and associated consultation (Anaes.)
Fee 14224	<b>Fee:</b> \$73.20 <b>Benefit:</b> 75% = \$54.90 85% = \$62.25
	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
<b>Fee</b> 14227	(See para TN.1.18 of explanatory notes to this Category) <b>Fee:</b> $101.90$ <b>Benefit:</b> $75\% = 76.45$ $85\% = 86.65$
	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.)
<b>Fee</b> 14234	(See para TN.1.18 of explanatory notes to this Category) <b>Fee:</b> \$376.55 <b>Benefit:</b> 75% = \$282.45
	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.)
<b>Fee</b> 14237	(See para TN.1.18 of explanatory notes to this Category) <b>Fee:</b> \$686.65 <b>Benefit:</b> 75% = \$515.00
	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
<b>Fee</b> 14245	(See para TN.1.19 of explanatory notes to this Category)Fee: $\$101.90$ Benefit: $75\% = \$76.45$ $85\% = \$86.65$
	Extracorporeal photopheresis for the treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if
	<ul> <li>a. the service is provided in the initial six months of treatment; and</li> <li>b. the service is delivered using an integrated, closed extracorporeal photopheresis system; and</li> <li>c. the patient is 18 years old or over; and</li> <li>d. the patient has received prior systemic treatment for this condition and experienced either disease progression or unacceptable toxicity while on this treatment; and</li> <li>e. the service is provided in combination with the use of Pharmaceutical Benefits Schemesubsidised methoxsalen; and</li> <li>f. the service is supervised by a specialist or consultant physician in the speciality of haematology.</li> </ul>
	Applicable once per treatment cycle
<b>Fee</b> 14247 S	

T1. MISC PROCEI	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDURES
	<b>Fee:</b> \$1,925.55 <b>Benefit:</b> 75% = \$1444.20 85% = \$1840.85
	<ul> <li>Fee: \$1,925.55 Benefit: 75% = \$1444.20 85% = \$1840.85</li> <li>Extracorporeal photopheresis for the continuing treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if <ul> <li>a. in the preceding 6 months:</li> <li>(i) a service to which item 14247 applies has been provided; and</li> <li>(ii) the patient has demonstrated a response to this service; and</li> <li>(iii) the patient requires further treatment; and</li> <li>b. the service is delivered using an integrated, closed extracorporeal photopheresis system; and</li> <li>c. the patient is 18 years old or over; and</li> <li>d. the service is provided in combination with the use of Pharmaceutical Benefits Schemesubsidised methoxsalen; and</li> <li>e. the service is supervised by a specialist or consultant physician in the speciality of haematology.</li> </ul> </li> </ul>
<b>Fee</b> 14249 S	Applicable once per treatment cycle (See para TN.1.25 of explanatory notes to this Category) Fee: \$1,925.55 Benefit: 75% = \$1444.20 85% = \$1840.85
	14. MANAGEMENT AND PROCEDURES CELLANEOUS THERAPEUTIC UNDERTAKEN IN AN EMERGENCY
	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.)
<b>Fee</b> 14255	(See para TN.1.24 of explanatory notes to this Category) <b>Fee:</b> \$154.40 <b>Benefit:</b> 75% = \$115.80 85% = \$131.25
	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.)
<b>Fee</b> 14256	(See para TN.1.24 of explanatory notes to this Category) <b>Benefit:</b> $75\% = $222.70$ $85\% = $252.40$
	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.)
<b>Fee</b> 14257	(See para TN.1.24 of explanatory notes to this Category)           Fee:         \$591.25         Benefit:         75% = \$443.45         85% = \$506.55
<b>Fee</b> 14258	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, 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, in conjunction with an attendance on the patient by the

	14. MANAGEMENT AND PROCEDURES CELLANEOUS THERAPEUTIC UNDERTAKEN IN AN EMERGENCY DURES 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) <b>Fee:</b> \$115.85 <b>Benefit:</b> 75% = \$86.90 85% = \$98.50
	Resuscitation of a patient provided for at least 1 hour but less than 2 hours, 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, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)
<b>Fee</b> 14259	(See para TN.1.24 of explanatory notes to this Category) <b>Fee:</b> \$222.70 <b>Benefit:</b> 75% = \$167.05 85% = \$189.30
	Resuscitation of a patient provided for at least 2 hours, 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, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)
<b>Fee</b> 14260	(See para TN.1.24 of explanatory notes to this Category) <b>Fee:</b> \$443.45 <b>Benefit:</b> 75% = \$332.60 85% = \$376.95
	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.)
<b>Fee</b> 14263	(See para TN.1.24 of explanatory notes to this Category) <b>Fee:</b> \$54.35 <b>Benefit:</b> 75% = \$40.80 85% = \$46.20
	Procedure (except a 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.)
<b>Fee</b> 14264	(See para TN.1.24 of explanatory notes to this Category) <b>Fee:</b> \$122.35 <b>Benefit:</b> 75% = \$91.80 85% = \$104.00
	Minor procedure on a patient by a medical practitioner (except a specialist in the practice of the specialist's speciality of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)
<b>Fee</b> 14265	(See para TN.1.24 of explanatory notes to this Category)Fee: $$40.75$ Benefit: $75\% = $30.60$ $85\% = $34.65$
	Procedure (except a minor procedure) on a patient 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, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)
<b>Fee</b> 14266	(See para TN.1.24 of explanatory notes to this Category) <b>Fee:</b> \$91.75 <b>Benefit:</b> 75% = \$68.85 85% = \$78.00
<b>Fee</b> 14270	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, 5013, 5014, 5016, 5017 or 5019; and

#### **14. MANAGEMENT AND PROCEDURES T1. MISCELLANEOUS THERAPEUTIC** UNDERTAKEN IN AN EMERGENCY PROCEDURES 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: \$137.15 **Benefit:** 75% = \$102.90 85% = \$116.60 Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a medical practitioner (except a specialist in the practice of the specialist's speciality of emergency medicine) in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (b) occurs at a recognised emergency department of a private hospital (Anaes.) (See para TN.1.24 of explanatory notes to this Category) Fee 14272 Fee: \$102.90 **Benefit:** 75% = \$77.20 85% = \$87.50 Application of chemical or physical restraint of 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 (See para TN.1.24 of explanatory notes to this Category) Fee **Benefit:** 75% = \$115.80 85% = \$131.25 Fee: \$154.40 14277 Application of chemical or physical restraint of a patient 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 (See para TN.1.24 of explanatory notes to this Category) Fee Fee: \$115.85 **Benefit:** 75% = \$86.90 85% = \$98.50 14278 Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by 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 14280 Fee: \$154.40 **Benefit:** 75% = \$115.80 85% = \$131.25 Anaesthesia (whether general anaesthesia or not) of a patient that: (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 Fee: \$115.85 **Benefit:** 75% = \$86.90 85% = \$98.50 14283 Emergent intubation, airway management or both of a patient that: (a) is managed by 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 **Benefit:** 75% = \$115.80 85% = \$131.25 14285 Fee: \$154.40 Emergent intubation, airway management or both of a patient that: Fee

# 14. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN EMERGENCY DEPARTMENT

<b>Fee</b> 15012	<b>RADIOTHERA</b> <b>Fee:</b> \$55.60	APY, SUPERFICIAL each attendance at <b>Benefit:</b> 75% = \$41.70 85% = \$47.3	
<b>Fee</b> 15009	<b>Derived Fee:</b> T	The fee for item 15006 plus for each field in ex	ccess of 1, an amount of \$19.30
		superficial attendance at which a single do 5 additional fields	ose technique is applied - 2 or more fields up to
<b>Fee</b> 15006	- 1 field <b>Fee:</b> \$98.20	<b>Benefit:</b> 75% = \$73.65 85% = \$83.5	
<b>Fee</b> 15003		The fee for item 15000 plus for each field in exAPY, SUPERFICIAL, attendance at whic	
	not being a serv		ys, radium rays or other radioactive substances), applies - each attendance at which fractionated f 5 additional fields
Fee 15000	Fee: \$44.30	<b>Benefit:</b> 75% = \$33.25 85% = \$37.7	70
	- 1 field		
	RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given		
	(Benefits for ad	ministration of general anaesthetic for ra	adiotherapy are payable under Group T10)
	Subgroup 1. Superficial		
	Group T2. Rad	liation Oncology	
T2. RAI			1. SUPERFICIAL
	(See para TN.1.24 <b>Fee:</b> \$115.85	4 of explanatory notes to this Category) Benefit: 75% = \$86.90 85% = \$98.5	50
14288	emergency med (b) occurs in co 5012, 5013, 501	dicine) at a recognised emergency departron pijunction with an attendance on the patie 14, 5016, 5017, 5019, 5021, 5022, 5027,	alist in the practice of the specialist's specialty of nent of a private hospital; and ent that is described in item 5001, 5004, 5011, 5030, 5031, 5032, 5033, 5035 or 5036; and st to which an item in Group T7 or T10 applies

	DIATION ONCOLOGY 2. ORTHOVOLTAGE		
	Subgroup 2. Orthovoltage		
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week		
	- 1 field		
<b>Fee</b> 15100	(See para TN.2.1 of explanatory notes to this Category)Fee: $$49.65$ Benefit: $75\% = $37.25$ $85\% = $42.25$		
	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 3 or more treatments per week - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)		
<b>Fee</b> 15103	(See para TN.2.1 of explanatory notes to this Category) <b>Derived Fee:</b> The fee for item 15100 plus for each field in excess of 1, an amount of \$19.55		
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently		
-	- 1 field		
<b>Fee</b> 15106	<b>Fee:</b> \$58.55 <b>Benefit:</b> 75% = \$43.95 85% = \$49.80		
	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)		
<b>Fee</b> 15109	<b>Derived Fee:</b> The fee for item 15106 plus for each field in excess of 1, an amount of \$23.60 <b>RADIOTHERAPY DEEP OR ORTHOVOL TAGE</b> attendance at which single dose technique is		
15109	Derived Fee: The fee for item 15106 plus for each field in excess of 1, an amount of \$23.60         RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field		
<b>Fee</b> 15109 <b>Fee</b> 15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is		
15109 Fee	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field		
15109 Fee 15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field         Fee: \$125.10       Benefit: 75% = \$93.85       85% = \$106.35         Radiotherapy, deep or orthovoltage attendance at which a single dose technique is applied - 2 or more		
15109 Fee 15112 Fee 15115	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field         Fee: \$125.10       Benefit: 75% = \$93.85       85% = \$106.35         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)		
15109 Fee 15112 Fee 15115	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field         Fee: \$125.10       Benefit: 75% = \$93.85       85% = \$106.35         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)         Derived Fee: The fee for item 15112 plus for each field in excess of 1, an amount of \$49.20		
15109 Fee 15112 Fee 15115	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field         Fee: \$125.10       Benefit: 75% = \$93.85       85% = \$106.35         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)         Derived Fee: The fee for item 15112 plus for each field in excess of 1, an amount of \$49.20         DIATION ONCOLOGY       3. MEGAVOLTAGE		
15109 Fee 15112 Fee 15115	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field         Fee: \$125.10       Benefit: 75% = \$93.85       85% = \$106.35         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)         Derived Fee: The fee for item 15112 plus for each field in excess of 1, an amount of \$49.20         DIATION ONCOLOGY       3. MEGAVOLTAGE         Group T2. Radiation Oncology		
15109 Fee 15112 Fee 15115	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field         Fee: \$125.10       Benefit: 75% = \$93.85       85% = \$106.35         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)         Derived Fee: The fee for item 15112 plus for each field in excess of 1, an amount of \$49.20         DIATION ONCOLOGY       3. MEGAVOLTAGE         Group T2. Radiation Oncology         Subgroup 3. Megavoltage         RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each		

T2. RAD	DIATION ONCOLOGY	3. MEGAVOLTAGE
	Radiation oncology treatment, using cobalt unit or caesium teletherapy treatment is given 2 or more fields up to a maximum of 5 additional fie fields)	
<b>Fee</b> 15214	<b>Derived Fee:</b> The fee for item 15211 plus for each field in excess of 1, an am	10unt of \$33.20
	RADIATION ONCOLOGY TREATMENT, using a single photon ene without electron facilities - each attendance at which treatment is given primary site (lung)	
Fee 15215	<b>Fee:</b> \$62.05 <b>Benefit:</b> 75% = \$46.55 85% = \$52.75	
	RADIATION ONCOLOGY TREATMENT, using a single photon ene without electron facilities - each attendance at which treatment is given primary site (prostate)	
Fee 15218	<b>Fee:</b> \$62.05 <b>Benefit:</b> 75% = \$46.55 85% = \$52.75	
	RADIATION ONCOLOGY TREATMENT, using a single photon ene without electron facilities - each attendance at which treatment is given primary site (breast)	
Fee 15221	<b>Fee:</b> \$62.05 <b>Benefit:</b> 75% = \$46.55 85% = \$52.75	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221	
Fee 15224	<b>Fee:</b> \$62.05 <b>Benefit:</b> 75% = \$46.55 85% = \$52.75	
	RADIATION ONCOLOGY TREATMENT, using a single photon ene without electron facilities - each attendance at which treatment is given secondary site	
Fee 15227	<b>Fee:</b> \$62.05 <b>Benefit:</b> 75% = \$46.55 85% = \$52.75	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung)	
Fee 15230	<b>Derived Fee:</b> The fee for item 15215 plus for each field in excess of 1, an arr	nount of \$39.50
	RADIATION ONCOLOGY TREATMENT, using a single photon ene without electron facilities - each attendance at which treatment is given maximum of 5 additional fields (rotational therapy being 3 fields) - trea (prostate)	rgy linear accelerator with or a - 2 or more fields up to a
Fee 15233	<b>Derived Fee:</b> The fee for item 15218 plus for each field in excess of 1, an am	nount of \$39.50
	RADIATION ONCOLOGY TREATMENT, using a single photon ene without electron facilities - each attendance at which treatment is given maximum of 5 additional fields (rotational therapy being 3 fields) - trea (breast)	rgy linear accelerator with or a - 2 or more fields up to a
Fee 15236	<b>Derived Fee:</b> The fee for item 15221 plus for each field in excess of 1, an am	nount of \$39.50
<b>Fee</b> 15239	RADIATION ONCOLOGY TREATMENT, using a single photon ene without electron facilities - each attendance at which treatment is given	rgy linear accelerator with or

T2. RAI	DIATION ONCOLOGY	3. MEGAVOLTAGE
	maximum of 5 additional fields (rotational therapy being 3 field for diseases and conditions not covered by items 15230, 15233	
	Derived Fee: The fee for item 15224 plus for each field in excess of	1, an amount of \$39.50
Fee	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 si	
15242	Derived Fee: The fee for item 15227 plus for each field in excess of	1, an amount of \$39.50
<b>F</b> .	RADIATION ONCOLOGY TREATMENT, using a dual photo minimum higher energy of at least 10MV photons, with electron treatment is given - 1 field - treatment delivered to primary site	n facilities - each attendance at which
Fee 15245	<b>Fee:</b> \$62.05 <b>Benefit:</b> 75% = \$46.55 85% = \$52.75	
T	RADIATION ONCOLOGY TREATMENT, using a dual photo minimum higher energy of at least 10MV photons, with electron treatment is given - 1 field - treatment delivered to primary site	n facilities - each attendance at which
Fee 15248	<b>Fee:</b> \$62.05 <b>Benefit:</b> 75% = \$46.55 85% = \$52.75	
	RADIATION ONCOLOGY TREATMENT, using a dual photo minimum higher energy of at least 10MV photons, with electron treatment is given - 1 field - treatment delivered to primary site	n facilities - each attendance at which
Fee 15251	<b>Fee:</b> \$62.05 <b>Benefit:</b> 75% = \$46.55 85% = \$52.75	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15245, 15248 or 15251	
Fee 15254	<b>Fee:</b> \$62.05 <b>Benefit:</b> 75% = \$46.55 85% = \$52.75	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site	
Fee 15257	<b>Fee:</b> \$62.05 <b>Benefit:</b> 75% = \$46.55 85% = \$52.75	
	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)	
Fee 15260	<b>Derived Fee:</b> The fee for item 15245 plus for each field in excess of	1. an amount of \$39.50
13200	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)	
Fee 15263	<b>Derived Fee:</b> The fee for item 15248 plus for each field in excess of	1. an amount of \$39.50
<b>Fee</b> 15266	RADIATION ONCOLOGY TREATMENT, using a dual photo minimum higher energy of at least 10MV photons, with electron treatment is given - 2 or more fields up to a maximum of 5 addir fields) - treatment delivered to primary site (breast)	n energy linear accelerator with a 1 facilities - each attendance at which

IZ. RAL	DIATION ONCOLOGY	3. MEGAVOLTAGE
	Derived Fee: The fee for item 15251 plus for each field in excess of 1, an	amount of \$39.50
	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 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266	
Fee 15269	<b>Derived Fee:</b> The fee for item 15254 plus for each field in excess of 1, an	amount of \$39.50
	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	
Fee 15272	<b>Derived Fee:</b> The fee for item 15257 plus for each field in excess of 1, an	amount of \$39.50
	RADIATION ONCOLOGY TREATMENT with IGRT imaging faci	ilities undertaken:
	(a) to implement an IMRT dosimetry plan prepared in accordance wi	ith item 15565; and
Fee	(b) utilising an intensity modulated treatment delivery mode (delivery linear accelerator or by a helical non C-arm based linear accelerator) which treatment is given.	
15275	<b>Fee:</b> \$190.35 <b>Benefit:</b> 75% = \$142.80 85% = \$161.80	
T2. RAI	DIATION ONCOLOGY	4. BRACHYTHERAPY
	Group T2. Radiation Oncology	
	Subgroup 4. Brachytherapy	
E	INTRAUTERINE TREATMENT ALONE using radioactive sealed than 115 days using manual afterloading techniques (Anaes.)	sources having a half-life greater
Fee 15303	<b>Fee:</b> \$371.45 <b>Benefit:</b> 75% = \$278.60 85% = \$315.75	
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	
Fee 15304	<b>Fee:</b> \$371.45 <b>Benefit:</b> 75% = \$278.60 85% = \$315.75	
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)	
Fee 15307	<b>Fee:</b> \$704.25 <b>Benefit:</b> 75% = \$528.20 85% = \$619.55	
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)	
Fee 15308	<b>Fee:</b> \$704.25 <b>Benefit:</b> 75% = \$528.20 85% = \$619.55	
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	
Fee		
15311	<b>Fee:</b> \$346.75 <b>Benefit:</b> 75% = \$260.10 85% = \$294.75	

T2. RAD	DIATION ONCOLOGY 4. BRACHYTHERAPY	
	than 115 days using automatic afterloading techniques (Anaes.)	
	<b>Fee:</b> \$344.20 <b>Benefit:</b> 75% = \$258.15 85% = \$292.60	
_	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)	
Fee 15315	<b>Fee:</b> \$680.70 <b>Benefit:</b> 75% = \$510.55 85% = \$596.00	
F	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)	
Fee 15316	<b>Fee:</b> \$680.70 <b>Benefit:</b> 75% = \$510.55 85% = \$596.00	
T	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	
Fee 15319	<b>Fee:</b> \$422.50 <b>Benefit:</b> 75% = \$316.90 85% = \$359.15	
Fee	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	
15320	<b>Fee:</b> \$422.50 <b>Benefit:</b> 75% = \$316.90 85% = \$359.15	
	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)	
<b>Fee</b> 15323	<b>Fee:</b> \$751.25 <b>Benefit:</b> 75% = \$563.45 85% = \$666.55	
	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)	
Fee 15324	<b>Fee:</b> \$751.25 <b>Benefit:</b> 75% = \$563.45 85% = \$666.55	
	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes.)	
Fee 15327	<b>Fee:</b> \$817.25 <b>Benefit:</b> 75% = \$612.95 85% = \$732.55	
	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.)	
Fee 15328	<b>Fee:</b> \$817.25 <b>Benefit:</b> 75% = \$612.95 85% = \$732.55	
	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.)	
Fee 15331	<b>Fee:</b> \$776.00 <b>Benefit:</b> 75% = \$582.00 85% = \$691.30	
<b>Fee</b> 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	

12. RAL	DIATION ONCOLOGY 4	. BRACHYTHERAPY
	exposure and using automatic afterloading techniques (Anaes.)	
	<b>Fee:</b> \$776.00 <b>Benefit:</b> 75% = \$582.00 85% = \$691.30	
_	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-lif including iodine, gold, iridium or tantalum) to a site where the volume treated in plane but does not require surgical exposure and using manual afterloading techn	volves only a single
<b>Fee</b> 15335	<b>Fee:</b> \$704.25 <b>Benefit:</b> 75% = \$528.20 85% = \$619.55	
	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.)	
<b>Fee</b> 15336	<b>Fee:</b> \$704.25 <b>Benefit:</b> 75% = \$528.20 85% = \$619.55	
	Prostate, radioactive seed implantation of, radiation oncology component, using t guidance:	ransrectal ultrasound
	(a) for a patient with:	
	(i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumo visible by imaging) or T2 (tumour confined within prostate); and	our not palpable or
	(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 dia	gnosis; 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	
<b>Fee</b> 15338	(See para TN.2.2 of explanatory notes to this Category) <b>Fee:</b> \$973.50 <b>Benefit:</b> 75% = \$730.15 85% = \$888.80	
	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.)	
<b>Fee</b> 15339	<b>Fee:</b> \$79.25 <b>Benefit:</b> 75% = \$59.45 85% = \$67.40	
	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	
<b>Fee</b> 15342	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites	
Fee		
15345	Fee: \$528.35       Benefit: 75% = \$396.30       85% = \$449.10         SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in i       15345 each attendance	tem 15342 or
<b>Fee</b> 15348	Fee: \$60.80 Benefit: 75% = \$45.60 85% = \$51.70	
Fee	CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIO	DACTIVE MOULD not

T2. RAD	DIATION ONCOLOGY	4. BRACHYTHERAPY
15351	exceeding 5 cm. diameter to an external surface	
	<b>Fee:</b> \$121.35 <b>Benefit:</b> 75% = \$91.05 85% = \$103.15	
	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface	
Fee 15354	<b>Fee:</b> \$147.20 <b>Benefit:</b> 75% = \$110.40 85% = \$125.15	
	"SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD, atternation and active mould constructed for application to an external surface of attendance which is the first attendance to apply the mould each attendance to apply the mould each attendance."	the patient other than an
Fee 15357	Fee: \$41.65         Benefit: 75% = \$31.25         85% = \$35.45	
T2. RAD	DIATION ONCOLOGY 5.	COMPUTERISED PLANNING
	Group T2. Radiation Oncology	
	Subgroup 5. Computerised Plannin	g
	RADIOTHERAPY PLANNING	
	RADIATION FIELD SETTING using a simulator or isocentric xray or single area for treatment by a single field or parallel opposed fields (no service to which item 15509 applies)	
<b>Fee</b> 15500	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$252.50 <b>Benefit:</b> 75% = \$189.40 85% = \$214.65	
	RADIATION FIELD SETTING using a simulator or isocentric xray or single area, where views in more than 1 plane are required for treatment (not being a service associated with a service to which item 15512 appl	t by multiple fields, or of 2 areas
<b>Fee</b> 15503	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$324.20 <b>Benefit:</b> 75% = \$243.15 85% = \$275.60	
	RADIATION FIELD SETTING using a simulator or isocentric xray or or more areas, or of total body or half body irradiation, or of mantle the irregularly shaped fields using multiple blocks, or of offaxis fields or se service associated with a service to which item 15515 applies)	erapy or inverted Y fields, or of
<b>Fee</b> 15506	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$484.15 <b>Benefit:</b> 75% = \$363.15 85% = \$411.55	
	RADIATION FIELD SETTING using a diagnostic xray unit of a singl field or parallel opposed fields (not being a service associated with a se applies)	
<b>Fee</b> 15509	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$218.80 <b>Benefit:</b> 75% = \$164.10 85% = \$186.00	
	RADIATION FIELD SETTING using a diagnostic xray unit of a singl 1 plane are required for treatment by multiple fields, or of 2 areas (not service to which item 15503 applies)	
<b>Fee</b> 15512	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$282.10 <b>Benefit:</b> 75% = \$211.60 85% = \$239.80	
Fee 15513	RADIATION SOURCE LOCALISATION using a simulator or x-ray 1	machine or CT of a single area,

T2. RAD	DIATION 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) <b>Fee:</b> \$318.95 <b>Benefit:</b> 75% = \$239.25 85% = \$271.15
	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)
<b>Fee</b> 15515	(See para TN.2.3 of explanatory notes to this Category)         Fee: \$408.45       Benefit: 75% = \$306.35       85% = \$347.20
	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
<b>Fee</b> 15518	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$80.10 <b>Benefit:</b> 75% = \$60.10 85% = \$68.10
	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
<b>Fee</b> 15521	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$353.70 <b>Benefit:</b> 75% = \$265.30 85% = \$300.65
	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
<b>Fee</b> 15524	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$663.15 <b>Benefit:</b> 75% = \$497.40 85% = \$578.45
	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
<b>Fee</b> 15527	(See para TN.2.3 of explanatory notes to this Category)Fee: $\$82.15$ Benefit: $75\% = \$61.65$ $85\% = \$69.85$
	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
<b>Fee</b> 15530	(See para TN.2.3 of explanatory notes to this Category)         Fee: \$366.40       Benefit: 75% = \$274.80       85% = \$311.45
	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
<b>Fee</b> 15533	(See para TN.2.3 of explanatory notes to this Category)           Fee:         \$694.80         Benefit:         75% = \$521.10         85% = \$610.10
	BRACHYTHERAPY PLANNING, computerised radiation dosimetry
<b>Fee</b> 15536	(See para TN.2.3 of explanatory notes to this Category)           Fee:         \$277.70         Benefit:         75% = \$208.30         85% = \$236.05
<b>Fee</b> 15539	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338

T2. RAD	DIATION ONCOLOGY 5. COMPUTERISED PLANNING
	(See para TN.2.3 of explanatory notes to this Category)           Fee: \$652.70         Benefit: 75% = \$489.55         85% = \$568.00
	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY without intravenous contrast medium, where:
	(a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and
	(b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and
	(c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and
	(d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images
<b>Fee</b> 15550	(See para TN.2.3 of explanatory notes to this Category)           Fee: \$685.30         Benefit: 75% = \$514.00         85% = \$600.60
	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY pre and post intravenous contrast medium, where:
	(a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and
	(b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and
	(c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and
	(d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images
<b>Fee</b> 15553	(See para TN.2.3 of explanatory notes to this Category)         Fee: \$739.35       Benefit: 75% = \$554.55       85% = \$654.65
	SIMULATION FOR INTENSITY-MODULATED RADIATION THERAPY (IMRT), with or without intravenous contrast medium, if:
	1. treatment set-up and technique specifications are in preparations for three-dimensional conformal radiotherapy dose planning; and
	2. patient set-up and immobilisation techniques are suitable for reliable CT-image volume data acquisition and three-dimensional conformal radiotherapy; and
	3. a high-quality CT-image volume dataset is acquired for the relevant region of interest to be planned and treated; and
	4. the image set is suitable for the generation of quality digitally-reconstructed radiographic images.
<b>Fee</b> 15555	(See para TN.2.3 of explanatory notes to this Category)           Fee:         \$739.35         Benefit:         75% = \$554.55         85% = \$654.65
<b>Fee</b> 15556	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 1 COMPLEXITY where:

T2. RAD	DIATION ONCOLOGY	5. COMPUTERISED PLANNING
	(a) dosimetry for a single phase three dimensional con dataset and having a single treatment target volume and	
	(b) one gross tumour volume or clinical target volume one relevant organ at risk as defined in the prescription	
	(c) the organ at risk must be nominated as a planning of specify the organ at risk dose goal or constraint; and	dose goal or constraint and the prescription must
	(d) dose volume histograms must be generated, approv	ved and recorded with the plan; and
	(e) a CT image volume dataset must be used for the re-	levant region to be planned and treated; and
	(f) the CT images must be suitable for the generation of images	of quality digitally reconstructed radiographic
	(See para TN.2.3 of explanatory notes to this Category)           Fee: \$691.35         Benefit: 75% = \$518.55         85% = \$60	06.65
	DOSIMETRY FOR THREE DIMENSIONAL CONFO COMPLEXITY where:	RMAL RADIOTHERAPY OF LEVEL 2
	(a) dosimetry for a two phase three dimensional confo dataset(s) with at least one gross tumour volume, two pl defined in the prescription; or	
	(b) dosimetry for a one phase three dimensional confo datasets with at least one gross tumour volume, one plan goals or constraints defined in the prescription; or	
	(c) image fusion with a secondary image (CT, MRI or organ at risk volumes in conjunction with and as specifi radiotherapy of level 1 complexity.	
	All gross tumour targets, clinical targets, planning targe prescription must be rendered as volumes. The organ at or constraints and the prescription must specify the orga volume histograms must be generated, approved and rec must be used for the relevant region to be planned and to generation of quality digitally reconstructed radiographi	risk must be nominated as planning dose goals ns at risk as dose goals or constraints. Dose corded with the plan. A CT image volume dataset reated. The CT images must be suitable for the
<b>Fee</b> 15559	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$901.65 <b>Benefit:</b> 75% = \$676.25 85% = \$81	6.95
	DOSIMETRY FOR THREE DIMENSIONAL CONFO COMPLEXITY - where:	RMAL RADIOTHERAPY OF LEVEL 3
	(a) dosimetry for a three or more phase three dimension volume dataset(s) with at least one gross tumour volume risk defined in the prescription; or	
<b>Fee</b> 15562	(b) dosimetry for a two phase three dimensional confo datasets with at least one gross tumour volume, and	rmal treatment plan using CT image volume

T2. RADI	ATION 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;
	or
	(d) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 2 complexity.
	All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images
	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$1,166.20 <b>Benefit:</b> 75% = \$874.65 85% = \$1081.50
	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
<b>Fee</b> 15565	(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	d by the radiation oncologist prior to delivery.
	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$3,448.10 <b>Benefit:</b> 75% = \$2586.10 85% = \$3363.40	
T2. RAI	DIATION ONCOLOGY	6. STEREOTACTIC RADIOSURGERY
	Group T2. Radiation Oncology	
	Subgroup 6.	Stereotactic Radiosurgery
	STEREOTACTIC RADIOSURGERY, includin simulation, dosimetry and treatment	ng all radiation oncology consultations, planning,
Fee 15600	<b>Fee:</b> \$1,771.30 <b>Benefit:</b> 75% = \$1328.50	85% = \$1686.60
T2. RAI	DIATION ONCOLOGY	7. RADIATION ONCOLOGY TREATMENT VERIFICATION
	Group T2. Radiation Oncology	
	Subgroup 7. Radiatio	n Oncology Treatment Verification
		ERIFICATION - single projection (with single or double a radiation oncologist and not associated with item 15705 s verified (ie maximum one per attendance).
<b>Fee</b> 15700	(See para TN.2.4 of explanatory notes to this Catego           Fee: \$47.85         Benefit: 75% = \$35.90         85	
	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).	
<b>Fee</b> 15705	(See para TN.2.4 of explanatory notes to this Catego           Fee: \$79.70         Benefit: 75% = \$59.80         85	
		ERIFICATION - volumetric acquisition, when prescribed associated with item 15700 or 15705 - each attendance re is verified (ie maximum one per attendance).
	(see para T2.5 of explanatory notes to this Cate	gory)
<b>Fee</b> 15710	(See para TN.2.4 of explanatory notes to this Catego <b>Fee:</b> \$79.70 <b>Benefit:</b> 75% = \$59.80 85	
		ERIFICATION of planar or volumetric IGRT for IMRT, ws or projections or 1 volumetric image set to facilitate a t field positioning, if:
_	(a) the treatment technique is classified as IMR	T; and
Fee 15715	(b) the margins applied to volumes (clinical target volume or planning target volume) are tailored or	

### 7. RADIATION ONCOLOGY TREATMENT 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)

 Fee: \$79.70
 Benefit: 75% = \$59.80
 85% = \$67.75

# **T2. RADIATION ONCOLOGY**

**T2. RADIATION ONCOLOGY** 

# Group T2. Radiation OncologySubgroup 8. Brachytherapy Planning And VerificationBRACHYTHERAPY TREATMENT VERIFICATION - maximum of one only for each attendance.Fee(See para TN.2.4 of explanatory notes to this Category)15800Fee: \$100.20Benefit: 75% = \$75.1585% = \$85.20RADIATION 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.FeeFee: \$207.60Benefit: 75% = \$155.7085% = \$176.50

# T2. RADIATION ONCOLOGY

### 10. TARGETED INTRAOPERATIVE RADIOTHERAPY

8. BRACHYTHERAPY PLANNING AND

VERIFICATION

	Group T2. Radiation Oncology
	Subgroup 10. Targeted Intraoperative Radiotherapy
	INTRAOPERATIVE RADIOTHERAPY
<b>Fee</b> 15900	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:

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 diam	meter) 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 invasiv unifocal on conventional examination and imaging; and	
	g) has no contra-indications to breast irradiation	
	Applicable only once per breast per lifetime (H)	
	<b>Fee:</b> \$260.10 <b>Benefit:</b> 75% = \$195.10	
T3. THE	RAPEUTIC NUCLEAR MEDICINE	
	Group T3. Therapeutic Nuclear Medicine	
	INTRACAVITY ADMINISTRATION OF A THERAPI preliminary paracentesis, not being a service associated which item 35404, 35406 or 35408 applies (Anaes.)	
<b>Fee</b> 16003	(See para TN.3.1 of explanatory notes to this Category) <b>Fee:</b> \$682.95 <b>Benefit:</b> 75% = \$512.25 85% = \$59	8.25
Ess	ADMINISTRATION OF A THERAPEUTIC DOSE OF technique	FIODINE 131 for thyroid cancer by single dose
Fee 16006	<b>Fee:</b> \$524.80 <b>Benefit:</b> 75% = \$393.60 85% = \$44	6.10
	ADMINISTRATION OF A THERAPEUTIC DOSE OF technique	FIODINE 131 for thyrotoxicosis by single dose
Fee 16009	<b>Fee:</b> \$358.15 <b>Benefit:</b> 75% = \$268.65 85% = \$30	4.45
<b>F</b>	INTRAVENOUS ADMINISTRATION OF A THERAP	PEUTIC DOSE OF PHOSPHOROUS 32
Fee 16012	<b>Fee:</b> \$309.85 <b>Benefit:</b> 75% = \$232.40 85% = \$26	3.40
	ADMINISTRATION OF STRONTIUM 89 for painful b where hormone therapy has failed and either:	bony metastases from carcinoma of the prostate
	(i) the disease is poorly controlled by conventional rad	liotherapy; or
Ess	(ii) conventional radiotherapy is inappropriate, due to t	the wide distribution of sites of bone pain
<b>Fee</b> 16015	<b>Fee:</b> \$4,289.45 <b>Benefit:</b> 75% = \$3217.10 85% = \$4	204.75
-	ADMINISTRATION OF $^{153}$ SM-LEXIDRONAM for th (as indicated by a positive bone scan) where hormonal th either the disease is poorly controlled by conventional ra inappropriate, due to the wide distribution of sites of bor	herapy and/or chemotherapy have failed and adiotherapy or conventional radiotherapy is
Fee	<b>Fee:</b> \$2,564.25 <b>Benefit:</b> 75% = \$1923.20 85% = \$2	

T4. OBS	STETRICS
	Group T4. Obstetrics
	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if:
	(a) the attendance is by video conference; and
	(b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and
	(c) the patient is not an admitted patient; and
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies
16399	(See para TN.4.12 of explanatory notes to this Category) <b>Derived Fee:</b> 50% of the fee for item 16401,16404,16406,16500,16590 or 16591. Benefit: 85% of the derived fee <b>Extended Medicare Safety Net Cap:</b> \$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
<b>Fee</b> 16400	(See para TN.4.1, TN.4.15 of explanatory notes to this Category) Fee: \$28.35 Benefit: 85% = \$24.10 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
<b>Fee</b> 16401	(See para TN.4.2 of explanatory notes to this Category) <b>Fee:</b> \$89.00 <b>Benefit:</b> 75% = \$66.75 85% = \$75.65 <b>Extended Medicare Safety Net Cap:</b> \$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.
<b>Fee</b> 16404	(See para AN.0.70, TN.4.2 of explanatory notes to this Category)         Fee: \$44.75       Benefit: 75% = \$33.60       85% = \$38.05         Extended Medicare Safety Net Cap: \$33.75

T4. OBS	OBSTETRICS	
	Antenatal professional attendance, by an obstetrician or general practitioner, as part of a single course of treatment when the patient is referred by a participating midwife. Payable only once for a pregnancy	
<b>Fee</b> 16406	Fee: \$139.40         Benefit: 75% = \$104.55         85% = \$118.50           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	
<b>Fee</b> 16407	(See para TN.4.13, TN.4.15 of explanatory notes to this Category)         Fee: \$74.60       Benefit: 75% = \$55.95       85% = \$63.45         Extended Medicare Safety Net Cap: \$48.50	
	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:	
l	(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	
<b>Fee</b> 16408	(See para TN.4.15 of explanatory notes to this Category)Fee: \$55.55Benefit: 85% = \$47.25Extended Medicare Safety Net Cap: \$36.15	
	ANTENATAL ATTENDANCE	
Fee	(See para TN.4.3, TN.4.15 of explanatory notes to this Category) <b>Fee:</b> $$49.05$ <b>Benefit:</b> $75\% = $36.80$ $85\% = $41.70$	
16500	Extended Medicare Safety Net Cap: \$33.75	
Fee	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication	

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16501	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) <b>Fee:</b> \$146.25 <b>Benefit:</b> 75% = \$109.70 85% = \$124.35	
	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	
<b>Fee</b> 16502	(See para TN.4.3 of explanatory notes to this Category)         Fee: \$49.05       Benefit: 75% = \$36.80       85% = \$41.70         Extended Medicare Safety Net Cap: \$22.50	
	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance	
<b>Fee</b> 16505	(See para TN.4.3 of explanatory notes to this Category)         Fee: \$49.05       Benefit: 75% = \$36.80       85% = \$41.70         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	
<b>Fee</b> 16508	(See para TN.4.3 of explanatory notes to this Category)Fee: $$49.05$ Benefit: $75\% = $36.80$ $85\% = $41.70$ Extended Medicare Safety Net Cap: $$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	
<b>Fee</b> 16509	(See para TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$49.05 <b>Benefit:</b> 75% = \$36.80 85% = \$41.70 <b>Extended Medicare Safety Net Cap:</b> \$22.50	
	CERVIX, purse string ligation of (Anaes.)	
<b>Fee</b> 16511	(See para TN.4.3 of explanatory notes to this Category)         Fee: \$228.85       Benefit: 75% = \$171.65       85% = \$194.55         Extended Medicare Safety Net Cap: \$112.30	
	CERVIX, removal of purse string ligature of (Anaes.)	
<b>Fee</b> 16512	(See para TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$66.05 <b>Benefit:</b> 75% = \$49.55 85% = \$56.15 <b>Extended Medicare Safety Net Cap:</b> \$33.75	
	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)	
<b>Fee</b> 16514	(See para TN.4.3 of explanatory notes to this Category)         Fee: \$38.15       Benefit: 75% = \$28.65       85% = \$32.45         Extended Medicare Safety Net Cap: \$16.90	
Fee	Management of vaginal birth as an independent procedure, if the patient's care has been transferred by	

	STETRICS
16515	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)
	<b>Fee:</b> \$656.40 <b>Benefit:</b> 75% = \$492.30 85% = \$571.70
	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.)
	(See para TN.4.5, TN.4.10 of explanatory notes to this Category)
Fee	<b>Fee:</b> \$468.90 <b>Benefit:</b> 75% = \$351.70 85% = \$398.60
16518	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.)
	(See para TN.4.5, TN.4.6, TN.4.10 of explanatory notes to this Category)
Fee	<b>Fee:</b> \$722.10 <b>Benefit:</b> 75% = \$541.60 85% = \$637.40
16519	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.)
	(See para TN.4.6, TN.4.10 of explanatory notes to this Category)
Fee	<b>Fee:</b> \$656.40 <b>Benefit:</b> 75% = \$492.30 85% = \$571.70
16520	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);
<b>Fee</b> 16522	(i) acute fetal compromise evidenced by:

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(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 $150 \ge 10^9$ /L; or	
(iv) uric acid greater than 0.36 mmol/L;	
(1) gestational diabetes mellitus requiring at least daily blood glucose monitoring;	
(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;	

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	(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;
1	(xi) thyrotoxicosis requiring medication;
	(xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium;
	(xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation;
	(xiv) HIV, hepatitis B or hepatitis C carrier status positive;
	(xv) red cell or platelet iso-immunisation;
	(xvi) cancer with metastatic disease;
	(xvii) illicit drug misuse during pregnancy (Anaes.)
	(See para TN.4.7 of explanatory notes to this Category) <b>Fee:</b> \$1,695.35 <b>Benefit:</b> 75% = \$1271.55
	Management of vaginal birth, if the patient's care has been transferred by a participating midwife for management of the birth, including all attendances related to the birth. Payable once only for a pregnancy.
	(Anaes.)
<b>Fee</b> 16527	(See para TN.4.8 of explanatory notes to this Category)         Fee: \$656.40       Benefit: 75% = \$492.30       85% = \$571.70         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.)
<b>Fee</b> 16528	(See para TN.4.8 of explanatory notes to this Category)         Fee: \$656.40       Benefit: 75% = \$492.30       85% = \$571.70         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.)
<b>Fee</b> 16530	(See para TN.4.5 of explanatory notes to this Category) <b>Fee:</b> \$399.90 <b>Benefit:</b> 75% = \$299.95 85% = \$339.95 <b>Extended Medicare Safety Net Cap:</b> \$259.95
	Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.)
<b>Fee</b> 16531	(See para TN.4.5, TN.4.14 of explanatory notes to this Category) <b>Fee:</b> \$799.85 <b>Benefit:</b> 75% = \$599.90
<b>Fee</b> 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. OBS	T4. OBSTETRICS	
	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) <b>Fee:</b> \$109.85 <b>Benefit:</b> 75% = \$82.40	
	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy	
<b>Fee</b> 16534	(See para TN.4.3, TN.4.14 of explanatory notes to this Category) <b>Fee:</b> \$109.85 <b>Benefit:</b> 75% = \$82.40	
	POST-PARTUM CARE EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)	
<b>Fee</b> 16564	(See para TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$226.80 <b>Benefit:</b> 75% = \$170.10 85% = \$192.80 <b>Extended Medicare Safety Net Cap:</b> \$224.50	
	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.)	
<b>Fee</b> 16567	(See para TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$331.70 <b>Benefit:</b> 75% = \$248.80 85% = \$281.95 <b>Extended Medicare Safety Net Cap:</b> \$224.50	
	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.)	
<b>Fee</b> 16570	(See para TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$432.90 <b>Benefit:</b> 75% = \$324.70 85% = \$368.00 <b>Extended Medicare Safety Net Cap:</b> \$224.50	
10070	CERVIX, repair of extensive laceration or lacerations (Anaes.)	
<b>Fee</b> 16571	(See para TN.4.10 of explanatory notes to this Category)         Fee: \$331.70       Benefit: 75% = \$248.80       85% = \$281.95         Extended Medicare Safety Net Cap: \$224.50	
	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)	
<b>Fee</b> 16573	(See para TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$270.30 <b>Benefit:</b> 75% = \$202.75 85% = \$229.80 <b>Extended Medicare Safety Net Cap:</b> \$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	
<b>Fee</b> 16590	(e) the service includes a mental health assessment (including screening for drug and alcohol use and	

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	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: \$387.85       Benefit: 75% = \$290.90       85% = \$329.70         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
<b>Fee</b> 16591	(See para TN.4.13, TN.4.9 of explanatory notes to this Category) <b>Fee:</b> \$148.40 <b>Benefit:</b> 75% = \$111.30 85% = \$126.15 <b>Extended Medicare Safety Net Cap:</b> \$112.30
	INTERVENTIONAL TECHNIQUES
<b>Fee</b> 16600	AMNIOCENTESIS, diagnostic (See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$66.05 Benefit: 75% = \$49.55 85% = \$56.15 Extended Medicare Safety Net Cap: \$33.75
	CHORIONIC VILLUS SAMPLING, by any route
<b>Fee</b> 16603	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$126.80 <b>Benefit:</b> 75% = \$95.10 85% = \$107.80 <b>Extended Medicare Safety Net Cap:</b> \$67.40
	Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)
<b>Fee</b> 16606	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)         Fee: \$253.10       Benefit: 75% = \$189.85       85% = \$215.15         Extended Medicare Safety Net Cap: \$134.80
	FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.)
<b>Fee</b> 16609	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)         Fee: \$516.10       Benefit: 75% = \$387.10       85% = \$438.70         Extended Medicare Safety Net Cap: \$258.25
Fee	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including
16612	neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a

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	service described in item 16609 (Anaes.)
	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)         Fee: \$406.05       Benefit: 75% = \$304.55       85% = \$345.15
	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.)
<b>Fee</b> 16615	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$216.30 <b>Benefit:</b> 75% = \$162.25 85% = \$183.90
	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated
<b>Fee</b> 16618	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)         Fee: \$216.30       Benefit: 75% = \$162.25       85% = \$183.90         Extended Medicare Safety Net Cap: \$106.70
	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios
<b>Fee</b> 16621	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$216.30 <b>Benefit:</b> 75% = \$162.25 85% = \$183.90
	FOETAL FLUID FILLED CAVITY, drainage of
<b>Fee</b> 16624	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)         Fee: \$311.25       Benefit: 75% = \$233.45       85% = \$264.60         Extended Medicare Safety Net Cap: \$145.95
	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis
<b>Fee</b> 16627	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)         Fee: \$633.65       Benefit: 75% = \$475.25       85% = \$548.95         Extended Medicare Safety Net Cap: \$314.35
1. COVID-19 OBSTETRIC TELEHEALTH T4. OBSTETRICS SERVICES	

# T4. OBSTETRICS

	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.	
<b>Fee</b> 91850	<b>Fee:</b> \$28.35 <b>Benefit:</b> 85% = \$24.10	
<b>Fee</b> 91851	Postnatal telehealth attendance by an obstetrician or general practitioner (other than a service to which	

T4. OBS	1. COVID-19 OBSTETRIC TELEHEALTH STETRICS SERVICES
	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 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
	<b>Fee:</b> \$74.60 <b>Benefit:</b> 85% = \$63.45
	Postnatal 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:
	(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.
	Applicable once for a pregnancy
Fee	
91852	Fee:         \$55.55         Benefit:         85% = \$47.25
	Antenatal telehealth attendance.
<b>Fee</b> 91853	<b>Fee:</b> \$49.05 <b>Benefit:</b> 85% = \$41.70
T4. OBS	TETRICS 2. COVID-19 OBSTETRIC PHONE SERVICES

T4. OBS	STETRICS     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.
<b>Fee</b> 91855	<b>Fee:</b> \$28.35 <b>Benefit:</b> 85% = \$24.10
91855	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 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	
91856	Fee: \$74.60Benefit: 85% = \$63.45Postnatal 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
<b>Fee</b> 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 not provided.	relation to which a service to which item 82130, 82135 or 82140 applies is
	Applicable once for a preg	nancy
	<b>Fee:</b> \$55.55 <b>Bene</b> f	<b>ïit:</b> 85% = \$47.25
	Antenatal phone attendance	2.
<b>Fee</b> 91858	Fee: \$49.05 Benef	<b>ät:</b> 85% = \$41.70
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 v	ideo conference; and
	(b) item 17610, 17615, 1	7620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and
	(c) the patient is not an ad	lmitted patient; and
	(d) the patient:	
	(i) is located both:	
	(A) within a te	elehealth eligible area; and
	(B) at the time	of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipie	ent in a residential care service; or
	(iii) is a patient of:	
	(A) an Aborig	inal Medical Service; or
	(B) an Aborig	inal Community Controlled Health Service;
	for which a di	rection made under subsection 19 (2) of the Act applies
17609	of the derived fee	ry notes to this Category) e for item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655. Benefit: 85% y Net Cap: 300% of the Derived fee for this item, or \$500.00, whichever is the lesse
<b>Fee</b> 17610	ANA	ESTHETIST, PRE-ANAESTHESIA CONSULTATION

T6. ANA	AESTHETICS 1. ANAESTHESIA CONSULTATIONS
	(Professional attendance by a medical practitioner in the practice of ANAESTHESIA)
	<ul> <li>a BRIEF consultation involving a targeted history and limited examination (including the cardio- respiratory system)</li> </ul>
	- 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: \$45.40       Benefit: 75% = \$34.05       85% = \$38.60         Extended Medicare Safety Net Cap: \$136.20
	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
<b>Fee</b> 17615	(See para TN.6.1 of explanatory notes to this Category) Fee: \$90.35 Benefit: 75% = \$67.80 85% = \$76.80 Extended Medicare Safety Net Cap: \$271.05
	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
<b>Fee</b> 17620	(See para TN.6.1 of explanatory notes to this Category) Fee: \$125.15 Benefit: 75% = \$93.90 85% = \$106.40 Extended Medicare Safety Net Cap: \$375.45
	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
<b>Fee</b> 17625	(See para TN.6.1 of explanatory notes to this Category)         Fee: \$159.35       Benefit: 75% = \$119.55       85% = \$135.45         Extended Medicare Safety Net Cap: \$478.05
	ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia)
<b>Fee</b> 17640	(Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her)

T6. AN/	AESTHETICS 1. ANAESTHESIA CONSULTATIONS
	- a BRIEF consultation involving a short history and limited examination
	- AND of not more than 15 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply
	(See para TN.6.2 of explanatory notes to this Category)         Fee: \$45.40       Benefit: 75% = \$34.05       85% = \$38.60         Extended Medicare Safety Net Cap: \$136.20
	- a consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan
	- AND of more than 15 minutes but not more than 30 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply.
<b>Fee</b> 17645	(See para TN.6.2 of explanatory notes to this Category)         Fee: \$90.35       Benefit: 75% = \$67.80       85% = \$76.80         Extended Medicare Safety Net Cap: \$271.05
	- 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
<b>Fee</b> 17650	(See para TN.6.2 of explanatory notes to this Category) Fee: \$125.15 Benefit: 75% = \$93.90 85% = \$106.40 Extended Medicare Safety Net Cap: \$375.45
	- 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.
<b>Fee</b> 17655	(See para TN.6.2 of explanatory notes to this Category)         Fee: \$159.35       Benefit: 75% = \$119.55       85% = \$135.45         Extended Medicare Safety Net Cap: \$478.05
	ANAESTHETIST, CONSULTATION, OTHER
<b>Fee</b> 17680	(Professional attendance by an anaesthetist in the practice of ANAESTHESIA)

T6. AN	AESTHETICS 1. ANAESTHESIA CONSULTATIONS
	- a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 - 3000 apply.
	(See para TN.6.3 of explanatory notes to this Category)Fee: $\$90.35$ Benefit: $75\% = \$67.80$ $85\% = \$76.80$ Extended Medicare Safety Net Cap: $\$271.05$
	- Where a pre-anaesthesia consultation covered by an item in the range 17615-17625 is performed in- rooms if:
	(a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and
	(b) the service is not provided to an admitted patient of a hospital; and
	(c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and
	(d) the service is of more than 15 minutes duration
	not being a service associated with a service to which items 2801 - 3000 apply.
<b>Fee</b> 17690	(See para TN.6.3 of explanatory notes to this Category) Fee: \$41.75 Benefit: 75% = \$31.35 85% = \$35.50 Extended Medicare Safety Net Cap: \$125.25
T7. RE	GIONAL OR FIELD NERVE BLOCKS
	Group T7. Regional Or Field Nerve Blocks
	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion
Fee 18213	<b>Fee:</b> \$92.20 <b>Benefit:</b> 75% = \$69.15 85% = \$78.40
	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner
	Applicable once per presentation, per medical practitioner, per complete new procedure (Anaes.)
<b>Fee</b> 18216	(See para TN.10.7 of explanatory notes to this Category)         Fee: \$197.60       Benefit: 75% = \$148.20       85% = \$168.00
<b>Fee</b> 18219	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by the medical practitioner extends beyond the first hour (Anaes.)

T7. REG	GIONAL OR FIELD NERVE BLOCKS
	<b>Derived Fee:</b> The fee for item 18216 plus \$19.80 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
<b>Fee</b> 18222	(See para TN.7.2, TN.10.7 of explanatory notes to this Category)Fee: $\$39.15$ Benefit: $75\% = \$29.40$ $85\% = \$33.30$
	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
<b>Fee</b> 18225	(See para TN.7.2, TN.10.7 of explanatory notes to this Category)           Fee: \$52.05         Benefit: 75% = \$39.05         85% = \$44.25
	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.
	Applicable once per presentation, per medical practitioner, per complete new procedure
<b>Fee</b> 18226	(See para TN.7.4, TN.10.7 of explanatory notes to this Category) <b>Fee:</b> \$296.35 <b>Benefit:</b> 75% = \$222.30 85% = \$251.90
	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.
<b>Fee</b> 18227	(See para TN.7.4, TN.10.7 of explanatory notes to this Category) <b>Derived Fee:</b> The fee for item 18226 plus \$29.75 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
Fee 18228	<b>Fee:</b> \$65.05 <b>Benefit:</b> 75% = \$48.80 85% = \$55.30
-	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.)
Fee 18230	<b>Fee:</b> \$248.10 <b>Benefit:</b> 75% = \$186.10 85% = \$210.90
	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.)
<b>Fee</b> 18232	(See para TN.7.3 of explanatory notes to this Category)Fee: $\$197.60$ Benefit: $75\% = \$148.20$ $85\% = \$168.00$
Ess	EPIDURAL INJECTION of blood for blood patch (Anaes.)
Fee 18233	<b>Fee:</b> \$197.60 <b>Benefit:</b> 75% = \$148.20 85% = \$168.00
	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.)
<b>Fee</b> 18234	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> $$129.90$ <b>Benefit:</b> $75\% = $97.45$ $85\% = $110.45$
-	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.)
Fee 18236	(See para TN.7.5 of explanatory notes to this Category)

T7. REG	GIONAL OR FIELD NERVE BLOCKS	
	<b>Fee:</b> \$65.05 <b>Benefit:</b> 75% = \$48.80 85% = \$55.30	
	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies	
<b>Fee</b> 18238	(See para TN.7.5 of explanatory notes to this Category)           Fee: \$39.15         Benefit: 75% = \$29.40         85% = \$33.30	
	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent	
<b>Fee</b> 18240	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$97.40 <b>Benefit:</b> 75% = \$73.05 85% = \$82.80	
	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.)	
<b>Fee</b> 18242	(See para TN.7.5 of explanatory notes to this Category)           Fee: \$39.15         Benefit: 75% = \$29.40         85% = \$33.30	
	VAGUS NERVE, injection of an anaesthetic agent	
<b>Fee</b> 18244	(See para TN.7.5 of explanatory notes to this Category)Fee: $$104.90$ Benefit: $75\% = $78.70$ $85\% = $89.20$	
	PHRENIC NERVE, injection of an anaesthetic agent	
<b>Fee</b> 18248	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$92.20$ Benefit: $75\% = \$69.15$ $85\% = \$78.40$	
	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent	
<b>Fee</b> 18250	(See para TN.7.5 of explanatory notes to this Category)           Fee: \$65.05         Benefit: 75% = \$48.80         85% = \$55.30	
	CERVICAL PLEXUS, injection of an anaesthetic agent	
<b>Fee</b> 18252	(See para TN.7.5 of explanatory notes to this Category)           Fee: \$104.90         Benefit: 75% = \$78.70         85% = \$89.20	
	BRACHIAL PLEXUS, injection of an anaesthetic agent	
<b>Fee</b> 18254	(See para TN.7.5 of explanatory notes to this Category)           Fee: \$104.90         Benefit: 75% = \$78.70         85% = \$89.20	
	SUPRASCAPULAR NERVE, injection of an anaesthetic agent	
<b>Fee</b> 18256	(See para TN.7.5 of explanatory notes to this Category)           Fee: \$65.05         Benefit: 75% = \$48.80         85% = \$55.30	
	INTERCOSTAL NERVE (single), injection of an anaesthetic agent	
<b>Fee</b> 18258	(See para TN.7.5 of explanatory notes to this Category)           Fee: \$65.05         Benefit: 75% = \$48.80         85% = \$55.30	
	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent	
<b>Fee</b> 18260	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$92.20$ Benefit: $75\% = \$69.15$ $85\% = \$78.40$	
	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.)	
<b>Fee</b> 18262	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$65.05 <b>Benefit:</b> 75% = \$48.80 85% = \$55.30	

T7. REC	GIONAL OR FIELD NERVE BLOCKS
	PUDENDAL NERVE and or dorsal nerve, injection of anaesthetic agent
<b>Fee</b> 18264	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$104.90 <b>Benefit:</b> 75% = \$78.70 85% = \$89.20
	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
<b>Fee</b> 18266	(See para TN.7.5 of explanatory notes to this Category)           Fee:         \$65.05         Benefit:         75% = \$48.80         85% = \$55.30
	OBTURATOR NERVE, injection of an anaesthetic agent
<b>Fee</b> 18268	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> $\$92.20$ <b>Benefit:</b> $75\% = \$69.15$ $85\% = \$78.40$
	FEMORAL NERVE, injection of an anaesthetic agent
<b>Fee</b> 18270	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$92.20$ Benefit: $75\% = \$69.15$ $85\% = \$78.40$
	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent
<b>Fee</b> 18272	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$65.05 <b>Benefit:</b> 75% = \$48.80 85% = \$55.30
	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level)
<b>Fee</b> 18274	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$92.20$ Benefit: $75\% = \$69.15$ $85\% = \$78.40$
	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)
<b>Fee</b> 18276	(See para TN.7.5 of explanatory notes to this Category)Fee: $$129.90$ Benefit: $75\% = $97.45$ $85\% = $110.45$
	SCIATIC NERVE, injection of an anaesthetic agent
<b>Fee</b> 18278	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$92.20$ Benefit: $75\% = \$69.15$ $85\% = \$78.40$
	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.)
<b>Fee</b> 18280	(See para TN.7.5 of explanatory notes to this Category)           Fee: \$129.90         Benefit: 75% = \$97.45         85% = \$110.45
	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure
<b>Fee</b> 18282	(See para TN.7.5 of explanatory notes to this Category)           Fee: \$104.90         Benefit: 75% = \$78.70         85% = \$89.20
	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.)
<b>Fee</b> 18284	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$153.60 <b>Benefit:</b> 75% = \$115.20 85% = \$130.60
	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.)
Fee	(See para TN.7.5 of explanatory notes to this Category)
18286	<b>Fee:</b> \$153.60 <b>Benefit:</b> 75% = \$115.20 85% = \$130.60

T7. RE0	IONAL OR FIELD NERVE BLOCKS	
	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.)	
<b>Fee</b> 18288	(See para TN.7.5 of explanatory notes to this Category)         Fee: \$153.60       Benefit: 75% = \$115.20       85% = \$130.60	
	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a	
Fee	service associated with the injection of botulinum toxin (Anaes.)	
18290	<b>Fee:</b> \$259.85 <b>Benefit:</b> 75% = \$194.90 85% = \$220.90	
	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.)	this
<b>Fee</b> 18292	(See para TN.7.5 of explanatory notes to this Category)           Fee: \$129.90         Benefit: 75% = \$97.45         85% = \$110.45	
	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.)	
Fee 18294	<b>Fee:</b> \$183.15 <b>Benefit:</b> 75% = \$137.40 85% = \$155.70	
	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	
Fee 18296	<b>Fee:</b> \$156.65 <b>Benefit:</b> 75% = \$117.50 85% = \$133.20	
18270	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by	v
	another medical practitioner	5
Fee 18297	<b>Fee:</b> \$61.75 <b>Benefit:</b> 75% = \$46.35 85% = \$52.50	
	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	
<b>Fee</b> 18298	Fee: \$183.15 Benefit: 75% = \$137.40 85% = \$155.70	
T8. SUF	GICAL OPERATIONS 1. GENER	RAL
	Group T8. Surgical Operations	
	Subgroup 1. General	
	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, bein service to which an item in this Group would have applied had the procedure not been discontinued of medical grounds	
30001	(See para TN.8.5 of explanatory notes to this Category) <b>Derived Fee:</b> 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 performed, including any associated consultation	is
Fee 30003	<b>Fee:</b> \$37.80 <b>Benefit:</b> 75% = \$28.35 85% = \$32.15	
	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at	
Ess	which the procedure is performed, including any associated consultation	
Fee 30006	Fee: \$48.40 Benefit: 75% = \$36.30 85% = \$41.15	
	LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	
Fee	<b>Fee:</b> \$76.95 <b>Benefit:</b> 75% = \$57.75	
30010	$\Gamma CC \cdot D(0, 7)$ Deficille (.) $\gamma 0 = 0.2 / . (.)$	

T8. SUF	RGICAL OPERATIONS	1. GENERAL	
	<b>Fee:</b> \$161.70 <b>Benefit:</b> 75% = \$121.30		
	BURNS, excision of, under general anaesthesia, involving not more than 10 per cen where grafting is not carried out during the same operation (Anaes.) (Assist.)	nt of body surface,	
<b>Fee</b> 30017	<b>Fee:</b> \$339.25 <b>Benefit:</b> 75% = \$254.45 85% = \$288.40		
Eas	BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.)		
Fee 30020	<b>Fee:</b> \$660.75 <b>Benefit:</b> 75% = \$495.60		
	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debride general anaesthesia or regional or field nerve block, including suturing of that wour (Anaes.) (Assist.)		
<b>Fee</b> 30023	(See para TN.8.6 of explanatory notes to this Category) <b>Fee:</b> \$339.25 <b>Benefit:</b> 75% = \$254.45 85% = \$288.40		
	WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical ind Gangrene, under general anaesthesia or regional or field nerve block, including sutt when performed (Anaes.) (Assist.)		
Fee 30024	<b>Fee:</b> \$339.25 <b>Benefit:</b> 75% = \$254.45 85% = \$288.40		
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR other than wound closure at time of surgery, not on face or neck, small (NOT MOR LONG), superficial, not being a service to which another item in Group T4 applies	RE THAN 7 CM	
<b>Fee</b> 30026	(See para TN.8.6 of explanatory notes to this Category) <b>Fee:</b> \$54.35 <b>Benefit:</b> 75% = \$40.80 85% = \$46.20		
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR of other than wound closure at time of surgery, not on face or neck, small (NOT MOR LONG), involving deeper tissue, not being a service to which another item in Grou	E THAN 7 CM	
<b>Fee</b> 30029	(See para TN.8.6 of explanatory notes to this Category)           Fee: \$93.65         Benefit: 75% = \$70.25         85% = \$79.65		
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR other than wound closure at time of surgery, on face or neck, small (NOT MORE T superficial (Anaes.)	· · · · · · · · · · · · · · · · · · ·	
<b>Fee</b> 30032	(See para TN.8.6 of explanatory notes to this Category) <b>Fee:</b> \$85.80 <b>Benefit:</b> 75% = \$64.35 85% = \$72.95		
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR other than wound closure at time of surgery, on face or neck, small (NOT MORE T involving deeper tissue (Anaes.)		
<b>Fee</b> 30035	(See para TN.8.6 of explanatory notes to this Category) <b>Fee:</b> \$122.35 <b>Benefit:</b> 75% = \$91.80 85% = \$104.00		
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR other than wound closure at time of surgery, not on face or neck, large (MORE TH superficial, not being a service to which another item in Group T4 applies (Anaes.)		
<b>Fee</b> 30038	(See para TN.8.6 of explanatory notes to this Category) <b>Fee:</b> \$93.65 <b>Benefit:</b> 75% = \$70.25 85% = \$79.65		
<b>Fee</b> 30042	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR other than wound closure at time of surgery, other than on face or neck, large (MO		

T8. SUR	GICAL OPERATIONS	1. GENERAL
	LONG), involving deeper tissue, other than a service to which another item in (Anaes.)	n Group T4 applies
	(See para TN.8.6 of explanatory notes to this Category)           Fee: \$193.10         Benefit: 75% = \$144.85         85% = \$164.15	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REI other than wound closure at time of surgery, on face or neck, large (MORE T superficial (Anaes.)	
<b>Fee</b> 30045	(See para TN.8.6 of explanatory notes to this Category) <b>Fee:</b> \$122.35 <b>Benefit:</b> 75% = \$91.80 85% = \$104.00	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REI other than wound closure at time of surgery, on face or neck, large (MORE T involving deeper tissue (Anaes.)	
<b>Fee</b> 30049	(See para TN.8.6 of explanatory notes to this Category) <b>Fee:</b> \$193.10 <b>Benefit:</b> 75% = \$144.85 85% = \$164.15	
E	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, rep apposition of each layer of tissue (Anaes.) (Assist.)	pair of, with accurate
Fee 30052	<b>Fee:</b> \$264.25 <b>Benefit:</b> 75% = \$198.20 85% = \$224.65	
Amend Fee	Wounds, dressing of, under general, regional or intravenous sedation, with or sutures, other than a service associated with a service to which another item i (Anaes.)	
30055	Fee: \$76.95         Benefit: 75% = \$57.75         85% = \$65.45	
Fee	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesis procedure (Anaes.)	a, as an independent
30058	Fee: \$150.20         Benefit: 75% = \$112.65         85% = \$127.70	
F	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea independent procedure (Anaes.)	or sclera), as an
Fee 30061	Fee: \$24.45 Benefit: 75% = \$18.35 85% = \$20.80	
	Etonogestrel subcutaneous implant, removal of, as an independent procedure	(Anaes.)
Fee 30062	<b>Fee:</b> \$63.20 <b>Benefit:</b> 75% = \$47.40 85% = \$53.75	
	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and ex of wound if performed, as an independent procedure (Anaes.)	ploration, including closure
Fee 30064	<b>Fee:</b> \$114.30 <b>Benefit:</b> 75% = \$85.75 85% = \$97.20	
-	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an indepen procedure (Anaes.) (Assist.)	
Fee 30068	<b>Fee:</b> \$288.00 <b>Benefit:</b> 75% = \$216.00 85% = \$244.80	
	Diagnostic biopsy of skin, as an independent procedure, if the biopsy specime examination (Anaes.)	en is sent for pathological
Fee	(See para TN.8.7 of explanatory notes to this Category) <b>Fee:</b> $$54.35$ <b>Benefit:</b> $75\% = $40.80$ $85\% = $46.20$	
30071	Extended Medicare Safety Net Cap: \$43.50	

T8. SUF	RGICAL OPERATIONS 1. GENERA	۱L
	Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	or
<b>Fee</b> 30072	(See para TN.8.7 of explanatory notes to this Category)Fee: $$54.35$ Benefit: $75\% = $40.80$ $85\% = $46.20$	
_	DIAGNOSTIC BIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	
Fee 30075	<b>Fee:</b> \$155.85 <b>Benefit:</b> 75% = \$116.90 85% = \$132.50	
	DIAGNOSTIC DRILL BIOPSY OF LYMPH NODE, DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)	
Fee 30078	(See para TN.8.7 of explanatory notes to this Category)Fee: $$50.45$ Benefit: $75\% = $37.85$ $85\% = $42.90$	
	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.)	
Fee 30081	(See para TN.8.7 of explanatory notes to this Category)Fee: $\$114.30$ Benefit: $75\% = \$85.75$ $\$5\% = \$97.20$	
	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.)	
Fee 30084	(See para TN.8.7 of explanatory notes to this Category)Fee: $\$61.20$ Benefit: $75\% = \$45.90$ $85\% = \$52.05$	
	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.)	
Fee 30087	(See para TN.8.7 of explanatory notes to this Category)Fee: $\$30.60$ Benefit: $75\% = \$22.95$ $\$5\% = \$26.05$	
	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, whe the biopsy is sent for pathological examination (Anaes.)	re
Fee 30090	(See para TN.8.7 of explanatory notes to this Category) <b>Fee:</b> \$133.75 <b>Benefit:</b> 75% = \$100.35 85% = \$113.70	
	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.)	
Fee 30093	(See para TN.8.7 of explanatory notes to this Category)           Fee: \$178.50         Benefit: 75% = \$133.90         85% = \$151.75	
	DIAGNOSTIC PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imagin techniques - but not including imaging, where the biopsy is sent for pathological examination (Anaes.)	
Fee 30094	(See para TN.8.7 of explanatory notes to this Category) <b>Fee:</b> $\$197.10$ <b>Benefit:</b> $75\% = \$147.85$ $\$5\% = \$167.55$	
	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:	l
	<ul> <li>a. serum cortisol at 0830-0930 hours on any day in the preceding month has been measured at greater than 100 nmol/L but less than 400 nmol/L; or</li> <li>b. in a patient who is acutely unwell and adrenal insufficiency is suspected.</li> </ul>	
Fee 30097	(See para TN.8.139 of explanatory notes to this Category)	

T8. SUR	GICAL OPERAT	IONS 1. GENER	RAL		
	Fee: \$101.10	<b>Benefit:</b> 75% = \$75.85 85% = \$85.95			
	SINUS, excision	of, involving superficial tissue only (Anaes.)			
<b>Fee</b> 30099	Fee: \$93.65	<b>Benefit:</b> 75% = \$70.25 85% = \$79.65			
	SINUS, excision	of, involving muscle and deep tissue (Anaes.)			
<b>Fee</b> 30103	Fee: \$191.35	<b>Benefit:</b> 75% = \$143.55 85% = \$162.65			
Amend Fee	Pre-auricular sin	us, excision of, on a patient 10 years of age or over (Anaes.)			
30104	Fee: \$132.10	<b>Benefit:</b> 75% = \$99.10 85% = \$112.30			
Amend	Pre-auricular sin	us, excision of, on a patient under 10 years of age (Anaes.)			
Fee 30105	Fee: \$171.65	<b>Benefit:</b> 75% = \$128.75 85% = \$145.95			
Amend	Excision of gang applies (Anaes.)	lion, other than a service associated with a service to which another item in this Gro	oup		
Fee 30107	Fee: \$228.85	<b>Benefit:</b> 75% = \$171.65 85% = \$194.55			
	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.) (As	sist.)			
<b>Fee</b> 30165	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$473.30 <b>Benefit:</b> 75% = \$355.00				
	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:				
	(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; and				
	(d) the procedure involves 1 excision only				
	(H) (Anaes.) (As	ssist.)			
<b>Fee</b> 30168	(See para TN.8.8 c <b>Fee:</b> \$473.30	of explanatory notes to this Category) Benefit: 75% = \$355.00			
<b>Fee</b> 30171		ge excision of redundant non abdominal skin and fat that is a direct consequence of nt loss, not being a service associated with a service to which item 30165, 30168, 30	172,		

T8. SUF	RGICAL OPERATIONS 1. GENE	RAL
	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 month conventional (or non surgical) treatment; and	s 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 prior to the lipectomy; and	
	(d) the procedure involves 2 excisions only	
	(H) (Anaes.) (Assist.)	
	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$719.75 <b>Benefit:</b> 75% = \$539.85	
	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, 30168, 30 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	171,
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 month conventional (or non surgical) treatment; and	s 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 prior to the lipectomy; and	
	(d) the procedure involves 3 or more excisions	
	(H) (Anaes.) (Assist.)	
<b>Fee</b> 30172	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$719.75 <b>Benefit:</b> 75% = \$539.85	
	Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneou tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associate with a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 45564 or 45565 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically remote (Anaes.) (Assist.)	ated
<b>Fee</b> 30176	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$1,025.60 <b>Benefit:</b> 75% = \$769.20	
	Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdominal skin and f 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:	fat
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 month conventional (or non surgical) treatment; and	is of
T	(b) the redundant skin and fat interferes with the activities of daily living; and	
Fee 30177	(c) the weight has been stable for at least 6 months following significant weight loss prior to the	

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	lipectomy
	(H) (Anaes.) (Assist.)
	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> $$1,025.60$ <b>Benefit:</b> $75\% = $769.20$
	Circumferential lipectomy, as an independent procedure, to correct circumferential excess of redundant skin and fat that is a direct consequence of significant weight loss, with or without a radical abdominoplasty (Pitanguy type or similar), not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if:
	(a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and
	(b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and
	(c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy
	(H) (Anaes.) (Assist.)
<b>Fee</b> 30179	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$1,262.30 <b>Benefit:</b> 75% = \$946.75
	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.)
Fee 30180	Fee: \$142.05         Benefit: 75% = \$106.55         85% = \$120.75
Б	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.)
Fee 30183	<b>Fee:</b> \$256.50 <b>Benefit:</b> 75% = \$192.40 85% = \$218.05
	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.)
<b>Fee</b> 30187	(See para TN.8.9 of explanatory notes to this Category)Fee: $$267.35$ Benefit: $75\% = $200.55$ $85\% = $227.25$
	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.)
<b>Fee</b> 30189	(See para TN.8.9 of explanatory notes to this Category) <b>Fee:</b> \$153.25 <b>Benefit:</b> 75% = \$114.95
	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.)
Fee 30190	<b>Fee:</b> \$413.85 <b>Benefit:</b> 75% = \$310.40 85% = \$351.80
<b>Fee</b> 30191	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

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	or other appropriate laser (or curettage and fine point diathermy for pyogenic granulo confirmed by the opinion of a specialist in the specialty of dermatology, one or more	
	<b>Fee:</b> \$66.05 <b>Benefit:</b> 75% = \$49.55 85% = \$56.15	
	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by abl or more lesions) (Anaes.)	ative technique (10
<b>Fee</b> 30192	(See para TN.8.9 of explanatory notes to this Category)           Fee: \$41.15         Benefit: 75% = \$30.90         85% = \$35.00	
	Malignant neoplasm of skin or mucous membrane that has been:	
	(a) proven by histopathology; or	
	(b) confirmed by the opinion of a specialist in the specialty of dermatology or plastic specimen has been submitted for histologic confirmation;	surgery where a
	removal of, by serial curettage, or carbon dioxide laser or erbium laser excision-ablat associated cryotherapy or diathermy (Anaes.)	ion, including any
<b>Fee</b> 30196	(See para TN.8.10 of explanatory notes to this Category) <b>Fee:</b> \$131.35 <b>Benefit:</b> 75% = \$98.55 85% = \$111.65	
	Malignant neoplasm of skin or mucous membrane proven by histopathology or confir of a specialist in the specialty of dermatology or plastic surgery—removal of, by liqu cryotherapy using repeat freeze thaw cycles	
Fee 30202	(See para TN.8.10 of explanatory notes to this Category) <b>Fee:</b> \$50.30 <b>Benefit:</b> 75% = \$37.75 85% = \$42.80	
	Skin lesions, multiple injections with glucocorticoid preparations (Anaes.)	
Fee 30207	<b>Fee:</b> \$46.40 <b>Benefit:</b> 75% = \$34.80 85% = \$39.45	
_	Keloid and other skin lesions, extensive, multiple injections of glucocorticoid prepara in the operating theatre of a hospital on a patient less than 16 years of age (Anaes.)	ations, if undertaken
Fee 30210	<b>Fee:</b> \$169.55 <b>Benefit:</b> 75% = \$127.20	
	HAEMATOMA, aspiration of (Anaes.)	
Fee 30216	<b>Fee:</b> \$28.45 <b>Benefit:</b> 75% = \$21.35 85% = \$24.20	
	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requ a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)	iiring admission to
Fee 30219	(See para TN.8.4 of explanatory notes to this Category)Fee: $$28.45$ Benefit: $75\% = $21.35$ $85\% = $24.20$	
	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or sim requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding afte	
<b>Fee</b> 30223	(See para TN.8.4 of explanatory notes to this Category) <b>Fee:</b> \$169.55 <b>Benefit:</b> 75% = \$127.20	
	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging not including imaging (Anaes.)	techniques - but
Fee 30224	<b>Fee:</b> \$247.20 <b>Benefit:</b> 75% = \$185.40 85% = \$210.15	
Fee	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques	s - but not including

T8. SUF		ONS 1. GENERAL		
30225	imaging (Anaes.)			
	Fee: \$278.55	<b>Benefit:</b> 75% = \$208.95 85% = \$236.80		
	MUSCLE, excisio	on of (LIMITED), or fasciotomy (Anaes.)		
Fee 30226	Fee: \$155.85	<b>Benefit:</b> 75% = \$116.90 85% = \$132.50		
	MUSCLE, excisio	on of (EXTENSIVE) (Anaes.) (Assist.)		
Fee 30229	Fee: \$284.00	<b>Benefit:</b> 75% = \$213.00 85% = \$241.40		
	MUSCLE, RUPT	URED, repair of (limited), not associated with external wound (Anaes.)		
Fee 30232	Fee: \$232.70	<b>Benefit:</b> 75% = \$174.55 85% = \$197.80		
	MUSCLE, RUPT	URED, repair of (extensive), not associated with external wound (Anaes.) (Assist.)		
Fee 30235	<b>Fee:</b> \$307.70	<b>Benefit:</b> 75% = \$230.80 85% = \$261.55		
		repair of, FOR HERNIATED MUSCLE (Anaes.)		
Fee 30238	<b>Fee:</b> \$155.85	<b>Benefit:</b> 75% = \$116.90 85% = \$132.50		
		R, INNOCENT, excision of, not being a service to which another item in this Group		
Fee	applies (Anaes.) (	Assist.)		
30241	Fee: \$370.80	<b>Benefit:</b> 75% = \$278.10 85% = \$315.20		
Fee	STYLOID PROC	ESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.)		
30244	Fee: \$370.80	<b>Benefit:</b> 75% = \$278.10		
Б	PAROTID DUCT	, repair of, using micro-surgical techniques (Anaes.) (Assist.)		
<b>Fee</b> 30246	Fee: \$717.75	<b>Benefit:</b> 75% = \$538.35		
5	PAROTID GLAND, total extirpation of (Anaes.) (Assist.)			
<b>Fee</b> 30247	Fee: \$769.30	<b>Benefit:</b> 75% = \$577.00		
	PAROTID GLAN	ND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.)		
Fee 30250	Fee: \$1,301.75	<b>Benefit:</b> 75% = \$976.35		
	RECURRENT PA	AROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.)		
Fee 30251	Fee: \$1,999.65	<b>Benefit:</b> 75% = \$1499.75 85% = \$1914.95		
		ND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.)		
Fee	(Assist.)			
30253	Fee: \$867.85	<b>Benefit:</b> 75% = \$650.90		
Fee	SUBMANDIBUI	AR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.)		
30255	Fee: \$1,155.65	<b>Benefit:</b> 75% = \$866.75		
Fee	SUBMANDIBUI	AR GLAND, extirpation of (Anaes.) (Assist.)		
30256	<b>Fee:</b> \$463.50	<b>Benefit:</b> 75% = \$347.65		
Fac	SUBLINGUAL C	GLAND, extirpation of (Anaes.)		
Fee 30259	Fee: \$206.60	<b>Benefit:</b> 75% = \$154.95 85% = \$175.65		

T8. SUR	GICAL OPERAT	TIONS 1. GENERAL		
	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.)			
Fee 30262	Fee: \$61.20	<b>Benefit:</b> 75% = \$45.90 85% = \$52.05		
	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.)			
Fee 30266	Fee: \$155.85	<b>Benefit:</b> 75% = \$116.90 85% = \$132.50		
Fee	SALIVARY GI	AND, repair of CUTANEOUS FISTULA OF (Anaes.)		
30269	Fee: \$155.85	<b>Benefit:</b> 75% = \$116.90 85% = \$132.50		
-	TONGUE, parti	al excision of (Anaes.) (Assist.)		
Fee 30272	Fee: \$307.70	<b>Benefit:</b> 75% = \$230.80 85% = \$261.55		
		CISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE NODES OF NECK (commandotype operation) (Anaes.) (Assist.)		
Fee 30275	Fee: \$1,834.15	<b>Benefit:</b> 75% = \$1375.65		
-	TONGUE TIE,	repair of, not being a service to which another item in this Group applies (Anaes.)		
Fee 30278	Fee: \$48.40	<b>Benefit:</b> 75% = \$36.30 85% = \$41.15		
Amend		dibular frenulum or maxillary frenulum, repair of, in a patient aged 2 years and over, naesthesia (Anaes.)		
Fee 30281	Fee: \$124.30	<b>Benefit:</b> 75% = \$93.25 85% = \$105.70		
	RANULA OR N	AUCOUS CYST OF MOUTH, removal of (Anaes.)		
Fee 30283	Fee: \$213.00	<b>Benefit:</b> 75% = \$159.75 85% = \$181.05		
Amend Fee	Branchial cyst,	removal of, on a patient 10 years of age or over (Anaes.) (Assist.)		
30286	Fee: \$413.95	<b>Benefit:</b> 75% = \$310.50 85% = \$351.90		
Amend Fee		removal of, on a patient under 10 years of age (Anaes.) (Assist.)		
30287	<b>Fee:</b> \$538.20	<b>Benefit:</b> 75% = \$403.65 85% = \$457.50		
Amend Fee	Branchial fistula	a, removal of, on a patient 10 years of age or over (Anaes.) (Assist.)		
30289	Fee: \$522.60	<b>Benefit:</b> 75% = \$391.95		
	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or			
Fee	without plastic i	repair (Anaes.) (Assist.)		
30293	Fee: \$463.50	<b>Benefit:</b> 75% = \$347.65 85% = \$394.00		
	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.)			
Fee 30294	Fee: \$1,834.15	<b>Benefit:</b> 75% = \$1375.65		
	THYROIDECT	OMY, total (Anaes.) (Assist.)		
Fee 30296	(See para TN.8.13 <b>Fee:</b> \$1,065.20	7 of explanatory notes to this Category) Benefit: 75% = \$798.90		
<b>Fee</b> 30297		OMY following previous thyroid surgery (Anaes.) (Assist.)		

T8. SUR	GICAL OPERATIONS	1. GENERAL
	(See para TN.8.138 of explanatory notes to this Category) <b>Fee:</b> \$1,065.20 <b>Benefit:</b> 75% = \$798.90	
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, no associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) (	ot being a service
Fee 30299	(See para TN.8.12 of explanatory notes to this Category) <b>Fee:</b> \$663.25 <b>Benefit:</b> 75% = \$497.45	
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving II/III axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection associated with a service to which item 30299, 30302 or 30303 applies (Anaes.) (	on, not being a service
<b>Fee</b> 30300	(See para TN.8.12 of explanatory notes to this Category) <b>Fee:</b> \$795.90 <b>Benefit:</b> 75% = \$596.95	
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving axilla, using lymphotropic dye injection, not being a service associated with a ser 30299, 30300 or 30303 applies (Anaes.) (Assist.)	
Fee 30302	(See para TN.8.12 of explanatory notes to this Category) <b>Fee:</b> \$530.60 <b>Benefit:</b> 75% = \$397.95	
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving II/III axilla, using lymphotropic dye injection, not being a service associated with item 30299, 30300 or 30302 applies (Anaes.) (Assist.)	
<b>Fee</b> 30303	(See para TN.8.12 of explanatory notes to this Category)Fee: $$636.65$ Benefit: $75\% = $477.50$	
	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.)	
Fee 30306	(See para TN.8.137, TN.8.138 of explanatory notes to this Category) <b>Fee:</b> \$831.00 <b>Benefit:</b> 75% = \$623.25	
	Partial or subtotal thyroidectomy (Anaes.) (Assist.)	
Fee 30310	(See para TN.8.137 of explanatory notes to this Category) <b>Fee:</b> \$831.00 <b>Benefit:</b> 75% = \$623.25	
Amend Fee	Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal du bone, on a patient 10 years of age or over (Anaes.) (Assist.)	ct and portion of hyoid
30314	<b>Fee:</b> \$475.90 <b>Benefit:</b> 75% = \$356.95	
	Minimally invasive parathyroidectomy. Removal of 1 or more parathyroid adeno cervical incision for an image localised adenoma, including thymectomy.	ma through a small
	For any particular patient - applicable only once per occasion on which the service	e is provided.
Fee	Not in association with a service to which item 30318, 30317 or 30320 applies. (A	Anaes.) (Assist.)
30315	<b>Fee:</b> \$1,186.10 <b>Benefit:</b> 75% = \$889.60	
	Redo parathyroidectomy. Cervical re-exploration for persistent or recurrent hyper including thymectomy and cervical exploration of the mediastinum.	rparathyroidism,
	For any particular patient - applicable only once per occasion on which the service	e is provided.
<b>Fee</b> 30317	Not in association with a service to which item 30315, 30318 or 30320 applies. (A	Anaes.) (Assist.)

T8. SUR	GICAL OPERATIC	NS	1. GENERAL
	Fee: \$1,420.20	<b>Benefit:</b> 75% = \$1065.15	
		ctomy, exploration and removal of 1 or more adenoma or hyperplast cluding thymectomy and cervical exploration of the mediastinum w	
	For any particular	patient - applicable only once per occasion on which the service is p	rovided.
Fee	Not in association	with a service to which item 30315, 30317 or 30320 applies. (Anaes	.) (Assist.)
30318	Fee: \$1,186.10	<b>Benefit:</b> 75% = \$889.60	
	Removal of a medi	astinal parathyroid adenoma via sternotomy or mediastinal thorasco	pic approach.
	For any particular	patient - applicable only once per occasion on which the service is p	rovided.
Fee	Not in association	with a service to which item 30315, 30317 or 30318 applies. (Anaes	.) (Assist.)
30320	Fee: \$1,420.20	<b>Benefit:</b> 75% = \$1065.15	
	Excision of phaeoc (Anaes.) (Assist.)	hromocytoma or extraadrenal paraganglioma via endoscopic or ope	n approach.
Fee 30323	Fee: \$1,420.20	<b>Benefit:</b> 75% = \$1065.15	
	Excision of an adre	enocortical tumour or hyperplasia via endoscopic or open approach.	(Anaes.) (Assist.)
Fee 30324	Fee: \$1,420.20	<b>Benefit:</b> 75% = \$1065.15	
Amend Fee		or fistula or both, radical removal of, including thyroglossal duct and under 10 years of age (Anaes.) (Assist.)	l portion of hyoid
30326	Fee: \$624.20	<b>Benefit:</b> 75% = \$468.15	
Ess	LYMPH NODES of	of GROIN, limited excision of (Anaes.)	
Fee 30329	Fee: \$256.95	<b>Benefit:</b> 75% = \$192.75 85% = \$218.45	
	LYMPH NODES of	of GROIN, radical excision of (Anaes.) (Assist.)	
Fee 30330	Fee: \$747.85	<b>Benefit:</b> 75% = \$560.90	
	LYMPH NODES of	of AXILLA, limited excision of (sampling) (Anaes.) (Assist.)	
Fee 30332	Fee: \$360.80	<b>Benefit:</b> 75% = \$270.60	
		of AXILLA, complete excision of, to level I (Anaes.) (Assist.)	
<b>Fee</b> 30335	(See para TN.8.13 of <b>Fee:</b> \$901.95	explanatory notes to this Category) <b>Benefit:</b> 75% = \$676.50	
		of AXILLA, complete excision of, to level II or level III (Anaes.) (A	ssist.)
<b>Fee</b> 30336	(See para TN.8.13 of <b>Fee:</b> \$1,082.40	explanatory notes to this Category) Benefit: 75% = \$811.80	
Amend	Enterocutaneous fi	stula, repair of, if dissection and resection of bowel is performed, w mation of a stoma (H) (Anaes.) (Assist.)	rith or without
Fee 30382	Fee: \$1,359.85	<b>Benefit:</b> 75% = \$1019.90	
Amend Fee 30384		invasive excision of a retroperitoneal mass, 4 cm or greater in large bours, other than a service to which another item in this Group app	

T8. SUR	GICAL OPERATI	ONS 1. GENER	۲AL
	(Assist.)		
	Fee: \$1,420.20	<b>Benefit:</b> 75% = \$1065.15	
Amend Fee	-	to theatre for laparotomy or laparoscopy for control or drainage of intra-abdominal owing abdominal surgery (H) (Anaes.) (Assist.)	
30385	Fee: \$586.15	<b>Benefit:</b> 75% = \$439.65	
Amend Fee		aparotomy when an operation is performed on abdominal, retroperitoneal or pelvic g lymph node biopsy, other than a service to which another item in this Group applie sist.)	es
30387	Fee: \$660.75	<b>Benefit:</b> 75% = \$495.60	
Amend Fee		bdominal trauma, including control of haemorrhage (with or without packing) and ontamination (H) (Anaes.) (Assist.)	
30388	Fee: \$1,108.20	<b>Benefit:</b> 75% = \$831.15	
		gnostic, with or without aspiration of fluid, on a patient 10 years of age or over, if no inal procedure is performed (H) (Anaes.) (Assist.)	0
<b>Amend</b> <b>Fee</b> 30390	(See para TN.8.15 ( <b>Fee:</b> \$228.85	of explanatory notes to this Category) Benefit: 75% = \$171.65	
Fac		EBULKING OPERATION for advanced intra-abdominal malignancy, with or with an independent procedure (Anaes.) (Assist.)	out
Fee 30392	Fee: \$701.85	<b>Benefit:</b> 75% = \$526.40	
Amend	without removal	paroscopy for generalised intra-peritoneal sepsis (also known as peritonitis), with or of foreign material or enteric contents, with lavage of the entire peritoneal cavity, with e of the abdomen when performed by laparotomy (H) (Anaes.) (Assist.)	
Fee 30396	Fee: \$1,057.75	<b>Benefit:</b> 75% = \$793.35	
Amend Fee		wound previously made and left open or closed, including change of dressings or thout drainage of loculated collections (H) (Anaes.)	
30397	Fee: \$241.75	<b>Benefit:</b> 75% = \$181.35	
Amend Fee	Laparostomy, fin (Anaes.) (Assist.)	al closure of wound made at previous operation, after removal of dressings or packs	
30399	Fee: \$332.50	<b>Benefit:</b> 75% = \$249.40	
_		WITH INSERTION OF PORTACATH for administration of cytotoxic therapy ent of reservoir (Anaes.) (Assist.)	
Fee 30400	Fee: \$658.10	<b>Benefit:</b> 75% = \$493.60	
	PARACENTESI	S ABDOMINIS (Anaes.)	
Fee 30406	<b>Fee:</b> \$54.35	<b>Benefit:</b> 75% = \$40.80 85% = \$46.20	
-		NOUS shunt, insertion of (Anaes.) (Assist.)	
<b>Fee</b> 30408	Fee: \$408.00	<b>Benefit:</b> 75% = \$306.00	
	LIVER BIOPSY,	percutaneous (Anaes.)	
Fee			

	DNS 1. GENERAL
	by wedge excision when performed in conjunction with another intraabdominal )
Fee: \$92.35	<b>Benefit:</b> 75% = \$69.30
LIVER BIOPSY b (Anaes.)	by core needle, when performed in conjunction with another intra-abdominal procedure
East \$54.50	$\mathbf{D}_{\mathrm{exc}}$
	<b>Benefit:</b> $75\% = $40.90$ $85\% = $46.35$
	ntal resection of, (local excision), other than for trauma (Anaes.) (Assist.)
	<b>Benefit:</b> 75% = \$538.35
LIVER, segmental	resection of, other than for trauma (Anaes.) (Assist.)
Fee: \$1,435.35	<b>Benefit:</b> 75% = \$1076.55
Liver cysts, greate	r than 5 cm in diameter, marsupialisation of 4 or less (Anaes.) (Assist.)
Fee: \$779.30	<b>Benefit:</b> 75% = \$584.50
Liver cysts, greate	r than 5 cm in diameter, marsupialisation of 5 or more (Anaes.) (Assist.)
Fee: \$1,168.90	<b>Benefit:</b> 75% = \$876.70
LIVER, lobectomy	y of, other than for trauma (Anaes.) (Assist.)
Fee: \$1,662.30	<b>Benefit:</b> 75% = \$1246.75
Liver tumour, othe	er than a hepatocellular carcinoma, destruction of one or more, by local ablation, other
than a service asso	ciated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.)
Fee: \$850.20	<b>Benefit:</b> 75% = \$637.65 85% = \$765.50
Liver, extended lo (Anaes.) (Assist.)	bectomy of, or central resections of segments 4, 5 and 8, other than for trauma
Fee: \$2,077.50	<b>Benefit:</b> 75% = \$1558.15
LIVER, repair of s	superficial laceration of, for trauma (Anaes.) (Assist.)
Fee: \$702.70	<b>Benefit:</b> 75% = \$527.05
LIVER, repair of c	leep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.)
Fee: \$1 359 85	<b>Benefit:</b> 75% = \$1019.90
	l resection of, for trauma (Anaes.) (Assist.)
<b>Fee:</b> \$1,624.25	<b>Benefit:</b> 75% = \$1218.20
LIVER, lobectomy	y of, for trauma (Anaes.) (Assist.)
Fee: \$1,737.65	<b>Benefit:</b> 75% = \$1303.25 85% = \$1652.95
	bectomy of, or central resections of segments 4, 5 and 8, for trauma (Anaes.) (Assist.)
Fee: \$2,417.40	<b>Benefit:</b> 75% = \$1813.05 85% = \$2332.70
	gle, open or minimally invasive abdominal drainage of, excluding aftercare (Anaes.)
(Assist.)	
<b>Fee:</b> \$542.40	<b>Benefit:</b> 75% = \$406.80 85% = \$461.05
	procedure (Anaes.)         Fee: \$92.35         LIVER BIOPSY b         (Anaes.)         Fee: \$54.50         LIVER, subsegment         Fee: \$717.75         LIVER, segmental         Fee: \$1,435.35         Liver cysts, greate         Fee: \$1,435.35         Liver cysts, greate         Fee: \$1,168.90         LIVER, lobectomy         Fee: \$1,168.90         LIVER, lobectomy         Fee: \$1,662.30         Liver tumour, othe         than a service asso         Fee: \$1,662.30         Liver, extended lol         (Anaes.) (Assist.)         Fee: \$2,077.50         LIVER, repair of c         Fee: \$702.70         LIVER, repair of c         Fee: \$1,359.85         LIVER, segmental         Fee: \$1,624.25         LIVER, lobectomy         Fee: \$1,737.65         Liver, extended lol         Fee: \$1,737.65         Liver, extended lol         Fee: \$2,417.40         Liver abscess, sing         (Assist.)

T8. SUR	GICAL OPERAT	ONS 1. GENERAL	
Amend	Liver abscess, m (Assist.)	ultiple, open or minimally invasive abdominal drainage of, excluding aftercare (Anaes.)	
Fee 30433	Fee: \$755.45	<b>Benefit:</b> 75% = \$566.60	
	Intraoperative ul	rasound of biliary tract, or operative cholangiography, if the service:	
	(a) is performed	in association with an intra-abdominal procedure; and	
Amend	(b) is not associa	ted with a service to which item 30442 or 30445 applies (Anaes.) (Assist.)	
Fee 30439	Fee: \$193.10	<b>Benefit:</b> 75% = \$144.85	
	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.)	
Fee 30440	Fee: \$547.70	<b>Benefit:</b> 75% = \$410.80 85% = \$465.55	
Amend	Intraoperative ul	trasound for staging of intra-abdominal tumours (Anaes.)	
Fee 30441	Fee: \$143.10	<b>Benefit:</b> 75% = \$107.35	
	CHOLEDOCHO	SCOPY in conjunction with another procedure (Anaes.)	
Fee 30442	Fee: \$193.10	<b>Benefit:</b> 75% = \$144.85	
Amend	Cholecystectom	y, by any approach, without cholangiogram (Anaes.) (Assist.)	
Fee 30443	Fee: \$668.45	<b>Benefit:</b> 75% = \$501.35	
Amend	ultrasound of the	y, by any approach, with attempted or completed cholangiogram or intraoperative biliary system, when performed via laparoscopic or open approach or when conversion c to open approach is required (Anaes.) (Assist.)	
Fee 30445	Fee: \$865.85	<b>Benefit:</b> 75% = \$649.40	
Amend Fee		y, by any approach, involving removal of common duct calculi via the cystic duct, with nsertion (Anaes.) (Assist.)	
30448	Fee: \$1,012.35	<b>Benefit:</b> 75% = \$759.30	
Amend		with removal of common duct calculi via choledochotomy, by any approach, with or of a stent (Anaes.) (Assist.)	
Fee 30449	Fee: \$1,125.70	<b>Benefit:</b> 75% = \$844.30	
Amend	Calculus of bilia	y tract, extraction of, using interventional imaging techniques (Anaes.) (Assist.)	
Fee 30450	Fee: \$545.65	<b>Benefit:</b> 75% = \$409.25 85% = \$463.85	
-	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30440 applies (Anaes.) (Assist.)		
Fee 30451	Fee: \$278.55	<b>Benefit:</b> 75% = \$208.95 85% = \$236.80	
	CHOLEDOCHO (Anaes.) (Assist	SCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi	
Fee 30452	Fee: \$392.80	<b>Benefit:</b> 75% = \$294.60	
Amend Fee		without cholecystectomy, with or without removal of calculi (Anaes.) (Assist.)	

T8. SUR	GICAL OPERATIC	INS	1. GENERAL
30454	Fee: \$1,371.65	<b>Benefit:</b> 75% = \$1028.75	
Amend Fee	Choledochotomy v (Anaes.) (Assist.)	vith cholecystectomy, with removal of calculi, including biliary inte	stinal anastomosis
30455	Fee: \$1,371.65	<b>Benefit:</b> 75% = \$1028.75	
-	CHOLEDOCHOT (Assist.)	OMY, intrahepatic, involving removal of intrahepatic bile duct calc	uli (Anaes.)
Fee 30457	Fee: \$1,435.35	<b>Benefit:</b> 75% = \$1076.55 85% = \$1350.65	
Fee	calculi, sphincterot	AL OPERATION ON SPHINCTER OF ODDI, involving 1 or mor comy, sphincteroplasty, biopsy, local excision of peri-ampullary or of the pancreatic duct, pancreatic duct septoplasty, with or without ch	duodenal tumour,
30458	Fee: \$1,055.10	<b>Benefit:</b> 75% = \$791.35	
Eas		UODENOSTOMY, CHOLECYSTOENTEROSTOMY, EJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior ) (Assist.)	biliary surgery
<b>Fee</b> 30460	Fee: \$897.45	<b>Benefit:</b> 75% = \$673.10	
<b>Amend</b> <b>Fee</b> 30461	cancer or choledoc	of porta hepatis (including associated neuro-lymphatic tissue), for cathal cyst, including bile duct excision and biliary-enteric anastomose with a service to which item 30440, 30451 or 31454 applies (Anaes <b>Benefit:</b> 75% = \$1153.75	es, other than a
Amend Fee		of common hepatic duct and right and left hepatic ducts, with 2 duct cancer or choledochal cyst (Anaes.) (Assist.)	anastomoses, for
30463	Fee: \$1,888.75	<b>Benefit:</b> 75% = \$1416.60	
Amend	or choledochal cys (a) more than 2 and	of common hepatic duct and right and left hepatic ducts, for cancer, t, involving either or both of the following: astomoses; gment (or major portion of segment) of liver; (Anaes.) (Assist.)	suspected cancer
Fee		ment (of major portion of segment) of nver, (Anaes.) (Assist.)	
30464	Fee: \$2,266.50	<b>Benefit:</b> 75% = \$1699.90	
<b>Fee</b> 30469	BILIARY STRICT Fee: \$1,790.65	CURE, repair of, after 1 or more operations on the biliary tree (Anae Benefit: 75% = \$1343.00 85% = \$1705.95	es.) (Assist.)
Amend	Repair of bile duct injury, including immediate reconstruction, other than a service associated with a service to which item 30584 applies (Anaes.) (Assist.)		
Fee 30472	Fee: \$1,386.90	<b>Benefit:</b> 75% = \$1040.20	
	gastroscopy, duode	not being a service to which item 41816 or 41822 applies), enoscopy or panendoscopy (1 or more such procedures), with or wit ociated with a service to which item 30478 or 30479 applies. (Anae	
<b>Fee</b> 30473	(See para TN.8.17 of <b>Fee:</b> \$184.30	Explanatory notes to this Category) Benefit: $75\% = $138.25$ $85\% = $156.70$	
<b>Fee</b> 30475		ion of stricture of upper gastrointestinal tract (including the use of in re clinically indicated) (Anaes.)	maging

	RGICAL OPERATIONS       1. GENERA         (See para TN.8.17, TN.8.133 of explanatory notes to this Category)
	Fee:         \$363.10         Benefit:         75% = \$272.35         85% = \$308.65
	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
	(b) the procedures are for the treatment of one or more of the following:
	(i) upper gastrointestinal tract bleeding;
	(ii) polyps;
	(iii) removal of foreign body;
	(iv) oesophageal or gastric varices;
	(v) peptic ulcers;
	(vi) neoplasia;
	(vii) benign vascular lesions;
	(viii) strictures of the gastrointestinal tract;
	(ix) tumorous overgrowth through or over oesophageal stents;
	other than a service associated with a service to which item 30473 or 30479 applies (Anaes.)
F <b>ee</b> 30478	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> $$255.55$ <b>Benefit:</b> $75\% = $191.70$ $85\% = $217.25$
	Endoscopy with laser therapy, for the treatment of one or more of the following:
	(a) neoplasia;
	(b) benign vascular lesions;
F <b>ee</b> 30479	(c) strictures of the gastrointestinal tract;

T8. SUR	GICAL OPERATIONS 1. GENERA	۱L
	(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.)	
	(See para TN.8.17 of explanatory notes to this Category)           Fee:         \$495.35         Benefit:         75% = \$371.55         85% = \$421.05	
	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.)	
<b>Fee</b> 30481	(See para TN.8.17 of explanatory notes to this Category)         Fee: \$371.45       Benefit: 75% = \$278.60       85% = \$315.75	
	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.)	
Fee 30482	<b>Fee:</b> \$264.10 <b>Benefit:</b> 75% = \$198.10 85% = \$224.50	
	Gastrostomy button, caecostomy antegrade enema device (chait etc.) or stomal indwelling device:	
	(a) non-endoscopic insertion of; or	
	(b) non-endoscopic replacement of;	
Amend	on a patient 10 years of age or over, excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)	
<b>Fee</b> 30483	<b>Fee:</b> \$185.90 <b>Benefit:</b> 75% = \$139.45 85% = \$158.05	
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.)	
<b>Fee</b> 30484	(See para TN.8.17 of explanatory notes to this Category)         Fee: \$379.70       Benefit: 75% = \$284.80       85% = \$322.75	
	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.)	
<b>Fee</b> 30485	(See para TN.8.17 of explanatory notes to this Category)           Fee: \$586.15         Benefit: 75% = \$439.65         85% = \$501.45	
E	SMALL BOWEL INTUBATION as an independent procedure (Anaes.)	
Fee 30488	<b>Fee:</b> \$93.65 <b>Benefit:</b> 75% = \$70.25 85% = \$79.65	

T8. SUR	GICAL OPERATIO	NS 1. GENERA	
	OESOPHAGEAL	PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.)	
<b>Fee</b> 30490	(See para TN.8.17 o <b>Fee:</b> \$547.70	explanatory notes to this Category) Benefit: 75% = \$410.80 85% = \$465.55	
	BILE DUCT, ENI	OSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.)	
<b>Fee</b> 30491	(See para TN.8.17 o <b>Fee:</b> \$577.85	explanatory notes to this Category) <b>Benefit:</b> 75% = \$433.40 85% = \$493.15	
Fee		CUTANEOUS STENTING OF (including dilatation when performed), using ging techniques - but not including imaging (Anaes.)	
30492	Fee: \$819.20	<b>Benefit:</b> 75% = \$614.40	
	ENDOSCOPIC B	LIARY DILATATION (Anaes.)	
<b>Fee</b> 30494	(See para TN.8.17 o <b>Fee:</b> \$437.55	explanatory notes to this Category) Benefit: 75% = \$328.20	
Eas		S BILIARY DILATATION for biliary stricture, using interventional imaging t including imaging (Anaes.)	
Fee 30495	Fee: \$819.20	<b>Benefit:</b> 75% = \$614.40	
Amend	Gastroenterostomy (including gastroduodenostomy), enterocolostomy or enteroenterostomy, as an independent procedure or in combination with another procedure, only if required for irresectable obstruction, other than a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.)		
Fee 30515	Fee: \$732.90	<b>Benefit:</b> 75% = \$549.70	
Amend	Revision of gastro	enterostomy, pyloroplasty or gastroduodenostomy (Anaes.) (Assist.)	
Fee 30517	Fee: \$959.55	<b>Benefit:</b> 75% = \$719.70	
	Partial gastrectom apply (Anaes.) (As	v, not being a service associated with a service to which any of items 31569 to 31581 sist.)	
Fee 30518	Fee: \$1,027.50	<b>Benefit:</b> 75% = \$770.65	
Amend Fee		cm or greater in diameter, removal of, by local excision, by laparoscopic or open g any associated anastomosis, excluding polypectomy, other than a service to which (Anaes.) (Assist.)	
30520	Fee: \$884.00	<b>Benefit:</b> 75% = \$663.00	
<b>F</b>	GASTRECTOMY	, TOTAL, for benign disease (Anaes.) (Assist.)	
Fee 30521	Fee: \$1,503.40	<b>Benefit:</b> 75% = \$1127.55	
	Gastrectomy, total, and removal of lower oesophagus, performed by open or minimally invasive approach, with anastomosis in the mediastinum, including any of the following (if performed): (a) distal pancreatectomy; (b) nodal dissection;		
Amend Fee	(c) splenectomy (A	naes.) (Assist.)	
30526	<b>Fee:</b> \$2,243.70	<b>Benefit:</b> 75% = \$1682.80	
	ANTIREFLUX op (Anaes.) (Assist.)	eration by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophage	
<b>Fee</b> 30529	(See para TN.8.19 o <b>Fee:</b> \$1,359.85	explanatory notes to this Category) Benefit: 75% = \$1019.90	
50527	<b>ι ττ</b> , φ1,337.03	<b>Deficite:</b> $i J / 0 = \psi 1 0 1 J J 0$	

T8. SUR	GICAL OPERATI	ONS	1. GENERAL
	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (		ty (Anaes.) (Assist.)
<b>Fee</b> 30530	(See para TN.8.19 of explanatory notes to this Category) <b>Fee:</b> \$816.00 <b>Benefit:</b> 75% = \$612.00		
Amend Fee	Oesophagogastric myotomy (Heller's operation) by endoscopic, abdominal or thoracic approach, whether performed by open or minimally invasive approach, including fundoplication when performed laparoscopically (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category)		
30532	<b>Fee:</b> \$936.90	Benefit: 75% = \$702.70 ASTRIC MYOTOMY (Heller's operation) via abd	ominal or thoracic approach WITH
		, with or without closure of the diaphragmatic hia	
<b>Fee</b> 30533	(See para TN.8.19 ( <b>Fee:</b> \$1,114.40	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$835.80	
_	OESOPHAGUS,	local excision for tumour of (Anaes.) (Assist.)	
Fee 30559	Fee: \$884.00	<b>Benefit:</b> 75% = \$663.00 85% = \$799.30	
Amend Fee	Oesophageal perf (Anaes.) (Assist.)	foration, repair of, by abdominal or thoracic approa	ch, including thoracic drainage
30560	Fee: \$982.05	<b>Benefit:</b> 75% = \$736.55	
Amend Fee	Enterostomy or colostomy, closure of (not involving resection of bowel), on a patient 10 years of age or over (Anaes.) (Assist.)		
30562	<b>Fee:</b> \$619.05 <b>Benefit:</b> 75% = \$464.30		
	COLOSTOMY C (Assist.)	OR ILEOSTOMY, refashioning of, on a person 10	years of age or over (Anaes.)
Fee 30563	Fee: \$619.05	<b>Benefit:</b> 75% = \$464.30 85% = \$534.35	
	SMALL INTEST (Assist.)	INE, resection of, without anastomosis (including	formation of stoma) (Anaes.)
Fee 30565	Fee: \$906.65	<b>Benefit:</b> 75% = \$680.00	
	NOTE: Multiple Operation and Multiple Anaesthetic rules apply to this item		this item
Amend	Appendicectomy, when performed in conjunction with another intra-abdominal procedure and during which a specimen is collected and sent for pathological testing (Anaes.)		· · · · ·
<b>Fee</b> 30574	Fee: \$64.10	<b>Benefit:</b> 75% = \$48.10	
Amend	Initial pancreatic necrosectomy by open, laparoscopic or endoscopic approach, excluding aftercare (Anaes.) (Assist.)		
<b>Fee</b> 30577	Fee: \$1,133.30	<b>Benefit:</b> 75% = \$850.00	
Amend Fee	Distal pancreatectomy with splenic preservation, by open or minimally invasive approach (Anaes.) (Assist.)		
30583	Fee: \$1,617.35	<b>Benefit:</b> 75% = \$1213.05	
<b>Amend</b> Fee 30584		enectomy (Whipple's procedure), with or without ing (if performed):	preservation of pylorus, including

T8. SUR	GICAL OPERATI	ONS 1. GENERAL
	(a) cholecystector	ny; liary anastomosis;
		anastomosis (Anaes.) (Assist.)
	Fee: \$3,121.55	<b>Benefit:</b> 75% = \$2341.20
	PANCREATICO	-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.)
Fee 30589	Fee: \$1,301.75	<b>Benefit:</b> 75% = \$976.35
	PANCREATICO	-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.)
Fee 30590	Fee: \$1,435.35	<b>Benefit:</b> 75% = \$1076.55
		OMY, near total or total (including duodenum), with or without splenectomy (Anaes.)
Fee 30593	Fee: \$1,964.20	<b>Benefit:</b> 75% = \$1473.15 85% = \$1879.50
	PANCREATECT resection (Anaes.)	OMY for pancreatitis following previously attempted drainage procedure or partial (Assist.)
<b>Fee</b> 30594	Fee: \$2,266.50	<b>Benefit:</b> 75% = \$1699.90
	SPLENORRHAP	HY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.)
<b>Fee</b> 30596	Fee: \$933.65	<b>Benefit:</b> 75% = \$700.25
	SPLENECTOMY incision (Anaes.)	7, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal (Assist.)
Fee 30599	Fee: \$1,359.85	<b>Benefit:</b> 75% = \$1019.90
Amend		of diaphragmatic laceration or hernia, following recent trauma, by any approach, erformed in conjunction with another procedure indicated as a result of abdominal or aes.) (Assist.)
Fee 30600	<b>Fee:</b> \$808.60 <b>Benefit:</b> 75% = \$606.45	
Amend Fee	abdominal approa	ernia, congenital, or delayed presentation of traumatic rupture, repair of, by thoracic or tach, on a patient 10 years of age or over, other than a service to which any of items pply (Anaes.) (Assist.)
30601	Fee: \$996.10	<b>Benefit:</b> 75% = \$747.10
		RTENSION, oesophageal transection via stapler or oversew of gastric varices with or arisation (Anaes.) (Assist.)
Fee 30606	<b>Fee:</b> \$1,155.80 <b>Benefit:</b> 75% = \$866.85	
Amend	Small intestine, resection of, with anastomosis, on a patient under 10 years of age (Anaes.) (Assist.)	
Fee 30608	Fee: \$1,309.25	<b>Benefit:</b> 75% = \$981.95
Amend	Benign tumour of soft tissue (other than tumours of skin, cartilage and bone, simple lipomas covered by item 31345 and lipomata), removal of, by surgical excision, on a patient under 10 years of age, if the specimen excised is sent for histological confirmation of diagnosis, other than a service to which another item in this Group applies (Anaes.) (Assist.)	
<b>Fee</b> 30611	Fee: \$586.20	<b>Benefit:</b> 75% = \$439.65 85% = \$501.50
Amend Fee	Strangulated, inca	arcerated or obstructed hernia, repair of, without bowel resection, on a patient 10 years

T8. SUR	GICAL OPERATIO	DNS 1. GENERA
30615 of age or over (Anaes.) (Assist.)		aes.) (Assist.)
	Fee: \$542.40	<b>Benefit:</b> 75% = \$406.80
		eck, selective dissection of one or 2 lymph node levels involving removal of soft nodes from one side of the neck, on a patient under 10 years of age (Anaes.) (Assist.)
Amend Fee 30618	(See para TN.8.24 o <b>Fee:</b> \$543.40	f explanatory notes to this Category) Benefit: 75% = \$407.55 85% = \$461.90
Amend	Laparoscopic sple	nectomy, on a patient under 10 years of age (Anaes.) (Assist.)
Fee 30619	Fee: \$974.20	<b>Benefit:</b> 75% = \$730.65
Amend	or minimally inva	natic umbilical, epigastric or linea alba hernia requiring mesh or other repair, by open sive approach, in a patient 10 years of age or over, other than a service to which item oplies (Anaes.) (Assist.)
Fee 30621	Fee: \$424.00	<b>Benefit:</b> 75% = \$318.00
A	gastrotomy, reduc ulcer, simple repa	rostomy, colostomy, enterotomy, colotomy, cholecystostomy, gastrostomy, tion of intussusception, removal of Meckel's diverticulum, suture of perforated peptic ir of ruptured viscus, reduction of volvulus, pyloroplasty or drainage of pancreas, on a ears of age (Anaes.) (Assist.)
Amend Fee 30622	(See para TN.8.14 o <b>Fee:</b> \$705.15	f explanatory notes to this Category) Benefit: 75% = \$528.90
Amend Fee		ving division of peritoneal adhesions (if no other intra-abdominal procedure is patient under 10 years of age (Anaes.) (Assist.)
30623	<b>Fee:</b> \$705.15 <b>Benefit:</b> 75% = \$528.90	
Amend Fee		ving division of adhesions in association with another intra-abdominal procedure if the le the adhesions is between 45 minutes and 2 hours, on a patient under 10 years of age
30626	Fee: \$708.40	<b>Benefit:</b> 75% = \$531.30
Amend Fee	Laparoscopy, diagnostic, if no other intra-abdominal procedure is performed, on a patient under 10 years of age (H) (Anaes.) (See para TN.8.15 of explanatory notes to this Category)	
30627	<b>Fee:</b> \$297.55	<b>Benefit:</b> 75% = \$223.20
Fee	HYDROCELE, ta	
30628	<b>Fee:</b> \$37.05	<b>Benefit:</b> 75% = \$27.80 85% = \$31.50
	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, wi insertion of testicular prosthesis, other than a service associated with a service to which item 3 30635, 30641, 30643 or 30644 applies	
г	(Anaes.) (Assist.	)
Fee 30629	Fee: \$542.40	<b>Benefit:</b> 75% = \$406.80
_	Insertion of testicu	alar prosthesis, at least 6 months following orchidectomy (Anaes.) (Assist.)
Fee 30630	Fee: \$492.95	<b>Benefit:</b> 75% = \$369.75
<b>Fee</b> 30631	Hydrocele, remov	al of, other than a service associated with a service to which item 30641, 30642 or

T8. SUR	GICAL OPERAT	ONS 1. GENERA	AL
	30644 applies (A	naes.)	
	Fee: \$246.25	<b>Benefit:</b> 75% = \$184.70 85% = \$209.35	
	-	cal correction of, including microsurgical techniques, other than a service associated which item 30390, 30627, 30641, 30642 or 30644 applies—one procedure (Anaes.)	
Fee 30635	Fee: \$303.60	<b>Benefit:</b> 75% = \$227.70	
30033		on, caecostomy antegrade enema device (chait etc.) or stomal indwelling device, non	)-
Amend Fee	•	ion of, or non-endoscopic replacement of, on a patient under 10 years of age (Anaes.)	
30636	Fee: \$242.60	<b>Benefit:</b> 75% = \$181.95 85% = \$206.25	
Amend Fee	Enterostomy or age (Anaes.) (As	blostomy, closure of (not involving resection of bowel), on a patient under 10 years o ist.)	of
30637	Fee: \$804.90	<b>Benefit:</b> 75% = \$603.70	
Amend Fee	Colostomy or ile	ostomy, refashioning of, on a patient under 10 years of age (Anaes.) (Assist.)	
30639	Fee: \$804.90	<b>Benefit:</b> 75% = \$603.70 85% = \$720.20	
Amend	1 0	d irreducible scrotal hernia, if surgery exceeds 2 hours, in a patient 10 years of age o service to which item 30615, 30621, 30648, 30651 or 30655 applies (Anaes.) (Assisted to the structure of	
<b>Fee</b> 30640	Fee: \$952.05	<b>Benefit:</b> 75% = \$714.05	
Fee	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes.) (Assist.)		is
30641	Fee: \$424.00	<b>Benefit:</b> 75% = \$318.00	
	insertion of testion	dical, including spermatic cord, unilateral, for tumour, inguinal approach, with ular prosthesis, other than a service associated with a service to which item 30631, 643, 30644 or 45051 applies (Anaes.) (Assist.)	
Fee 30642	Fee: \$788.90	<b>Benefit:</b> 75% = \$591.70	
	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient under 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (Anaes.) (Assist.)		
Fee 30643	Fee: \$705.15	<b>Benefit:</b> 75% = \$528.90	
	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient at least 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (Anaes.) (Assist.)		
Fee 30644	Fee: \$542.40	<b>Benefit:</b> 75% = \$406.80	
Amend	Appendicectomy, on a patient under 10 years of age, other than a service to which item 30574 applies (Anaes.) (Assist.)		
Fee 30645	Fee: \$602.40	<b>Benefit:</b> 75% = \$451.80	
Amend		endicectomy, on a patient under 10 years of age (Anaes.) (Assist.)	
Fee 30646	Fee: \$602.40	<b>Benefit:</b> 75% = \$451.80	
<b>New</b> 30648		al hernia or infantile hydrocele, repair of, by open or minimally invasive approach, of of age or over, other than a service to which item 30615 or 30651 applies (Anaes.)	on

T8. SUR	GICAL OPERAT	IONS 1. GENERAL
	(Assist.)	
	Fee: \$483.35	<b>Benefit:</b> 75% = \$362.55
Amend	Haemorrhage, an years of age (An	rest of, following circumcision requiring general anaesthesia, on a patient under 10 aes.)
Fee 30649	Fee: \$195.25	<b>Benefit:</b> 75% = \$146.45 85% = \$166.00
	insertion of intra muscle toward th	epair involving primary fascial closure by suture, with or without onlay mesh or peritoneal onlay mesh repair, without closure of the defect or advancement of the rectus ne midline, by open or minimally invasive approach, in a patient 10 years of age or over, ice to which item 30621, 30655 or 30657 applies (Anaes.) (Assist.)
<b>New</b> 30651	Fee: \$542.40	<b>Benefit:</b> 75% = \$406.80
N	-	hernia regardless of size of defect, repair of, with or without mesh, by open or ive approach, in a patient 10 years of age or over (Anaes.) (Assist.)
New 30652	Fee: \$542.40	<b>Benefit:</b> 75% = \$406.80
Fee	Circumcision of applies	the penis, with topical or local analgesia, other than a service to which item 30658
30654	Fee: \$48.40	<b>Benefit:</b> 75% = \$36.30 85% = \$41.15
	Ventral hernia, repair of, with advancement of the rectus muscles to the midline using a retro-re peritoneal or sublay technique, by open or minimally invasive approach, in a patient 10 years of over, other than a service to which item 30621 or 30651 applies (Anaes.) (Assist.)	
New 30655	Fee: \$952.05	<b>Benefit:</b> 75% = \$714.05
	release and exter	ninal wall reconstruction with component separation, including transversus abdominus nal oblique release for abdominal wall closure by mobilising the rectus abdominis idline, by open or minimally invasive approach (Anaes.) (Assist.)
New 30657	Fee: \$1,355.65	<b>Benefit:</b> 75% = \$1016.75
_	Circumcision of the penis, when performed under general or regional anaesthesia and in conjunction with a service to which an item in Group T7 or Group T10 applies (Anaes.)	
Fee 30658	Fee: \$147.70	<b>Benefit:</b> 75% = \$110.80 85% = \$125.55
Amend	Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a patient 10 years of age or over (Anaes.)	
Fee 30663	Fee: \$150.20	<b>Benefit:</b> 75% = \$112.65 85% = \$127.70
	PARAPHIMOSIS or PHIMOSIS, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes.)	
Fee 30666	<b>Fee:</b> \$49.35	<b>Benefit:</b> 75% = \$37.05 85% = \$41.95
		ion of (Anaes.) (Assist.)
Fee 30672	Fee: \$463.50	<b>Benefit:</b> 75% = \$347.65
Amend	Pilonidal sinus o	r cyst, or sacral sinus or cyst, definitive excision of (Anaes.)
Fee		

T8. SUF	GICAL OPERATIONS 1. GENERAL
	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.)
Fee 30679	<b>Fee:</b> \$100.20 <b>Benefit:</b> 75% = \$75.15 85% = \$85.20
	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686)
	The patient to whom the service is provided must:
	(i) have recurrent or persistent bleeding; and
	(ii) be anaemic or have active bleeding; and
	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)
<b>Fee</b> 30680	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$1,217.40 <b>Benefit:</b> 75% = \$913.05 85% = \$1132.70
	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684)
	The patient to whom the service is provided must:
	(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.)
<b>Fee</b> 30682	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$1,217.40 <b>Benefit:</b> 75% = \$913.05 85% = \$1132.70
	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686)
	The patient to whom the service is provided must:
	(i) have recurrent or persistent bleeding; and
	(ii) be anaemic or have active bleeding; and
Fee 30684	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify

T8. SUF	RGICAL OPERATIONS 1. GENERA	۱L
	the cause of the bleeding.	
	(Anaes.)	
	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$1,498.20 <b>Benefit:</b> 75% = \$1123.65 85% = \$1413.50	
	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 identif the cause of the bleeding. (Anaes.)	fy
<b>Fee</b> 30686	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$1,498.20 <b>Benefit:</b> 75% = \$1123.65 85% = \$1413.50	
	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.)	
<b>Fee</b> 30687	(See para TN.8.17, TN.8.20 of explanatory notes to this Category)         Fee: \$495.35       Benefit: 75% = \$371.55       85% = \$421.05	
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	1
<b>Fee</b> 30688	(See para TN.8.21, TN.8.17 of explanatory notes to this Category)         Fee: \$379.70       Benefit: 75% = \$284.80       85% = \$322.75	
	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.)	
<b>Fee</b> 30690	(See para TN.8.21, TN.8.17 of explanatory notes to this Category)         Fee: \$586.15       Benefit: 75% = \$439.65       85% = \$501.45	
	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 i this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	in
Fee 30692	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$379.70 <b>Benefit:</b> 75% = \$284.80 85% = \$322.75	

T8. SUF	RGICAL OPERATIONS 1. GENE	RAL
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine need 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.)	
<b>Fee</b> 30694	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$586.15 <b>Benefit:</b> 75% = \$439.65 85% = \$501.45	
	Appendicectomy, on a patient 10 years of age or over, whether performed by: (a) laparoscopy or right iliac fossa open incision; or (b) conversion of a laparoscopy to an open right iliac fossa incision; other than a service to which item 30574 applies (Anaes.) (Assist.)	
<b>New</b> 30720	<b>Fee:</b> \$463.50 <b>Benefit:</b> 75% = \$347.65	
	Laparotomy or laparoscopy, or laparoscopy converted to laparotomy, with or without associated biopsies, including the division of adhesions (if performed, but only if the time taken to divide adhes is 45 minutes or less), if no other intra-abdominal procedure is performed (Anaes.) (Assist.)	ions
<b>New</b> 30721	<b>Fee:</b> \$502.85 <b>Benefit:</b> 75% = \$377.15	
<b>New</b> 30722	Laparotomy or laparoscopy, on a patient 10 years of age or over, including any of the following procedures (if performed, and including division of one or more adhesions, but only if the time taken divide the adhesions is 45 minutes or less): (a) colostomy; (b) colotomy; (c) cholecystostomy; (d) enterostomy; (e) enterotomy; (f) gastrostomy; (g) gastrotomy; (h) caecostomy; (i) gastric fixation by cardiopexy; (j) reduction of intussusception; (k) simple repair of ruptured viscus (including perforated peptic ulcer); (l) reduction of volvulus; (m) drainage of pancreas (Anaes.) (Assist.) Fee: \$542.40 Benefit: 75% = \$406.80	ı to
30722	Fee: \$542.40       Benefit: 75% = \$406.80         Laparotomy, laparoscopy or extra-peritoneal approach, for drainage of an intra-abdominal, pancreati	c or
<b>New</b> 30723	retroperitoneal collection or abscess (Anaes.) (Assist.) <b>Fee:</b> \$542.40 <b>Benefit:</b> 75% = \$406.80	
New	Laparotomy or laparoscopy with division of adhesions, lasting more than 45 minutes but less than 2 hours, performed either: (a) as a primary procedure; or (b) when the division of adhesions is performed in conjunction with another primary procedure—to provide access to a surgical field (but excluding mobilisation or normal anatomical dissection of the organ or structure for which the primary procedure is being carried out) (Anaes.) (Assist.)	
30724	Fee: \$544.95         Benefit: 75% = \$408.75	
N	Laparotomy or laparoscopy for intestinal obstruction or division of extensive, complex adhesions, lasting 2 hours or more, performed either: a) as a primary procedure; or	
<b>New</b> 30725	b) when the division of adhesions is performed in conjunction with another procedure—to provide	

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	access to a surgical field, but excluding mobilisa structure for which the other procedure is being	ation or normal anatomical dissection of the organ or carried out (Anaes.) (Assist.)
	<b>Fee:</b> \$965.75 <b>Benefit:</b> 75% = \$724.35	
Now	Small intestine, resection of, including either of (a) a small bowel diverticulum (such as Meckel <sup>2</sup> (b) stricturoplasty (Anaes.) (Assist.)	
<b>New</b> 30730	<b>Fee:</b> \$1,007.10 <b>Benefit:</b> 75% = \$755.35	
New	Intraoperative enterotomy for visualisation of th examination using a flexible endoscope, with or	e small intestine by endoscopy, including endoscopic without biopsies (Anaes.) (Assist.)
30731	<b>Fee:</b> \$755.45 <b>Benefit:</b> 75% = \$566.60	
New	Peritonectomy, lasting more than 5 hours, includ (Anaes.) (Assist.)	ling hyperthermic intra-peritoneal chemotherapy
30732	<b>Fee:</b> \$4,136.10 <b>Benefit:</b> 75% = \$3102.10	
	Oesophagectomy with colon or jejunal interposi (a) any gastrointestinal anastomoses (except vas (b) anastomoses in the chest or neck (if appropri One surgeon (Anaes.) (Assist.)	cular anastomoses); and
<b>New</b> 30750	<b>Fee:</b> \$2,145.80 <b>Benefit:</b> 75% = \$1609.35	
	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate) Conjoint surgery, principal surgeon (Anaes.) (Assist.)	
New 30751	<b>Fee:</b> \$2,145.80 <b>Benefit:</b> 75% = \$1609.35	
	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate) Conjoint surgery, co-surgeon (Anaes.) (Assist.)	
<b>New</b> 30752	<b>Fee:</b> \$1,609.35 <b>Benefit:</b> 75% = \$1207.05	
	Oesophagectomy, by any approach, including: (a) gastric reconstruction by abdominal mobilisa (b) anastomosis in the neck or chest One surgeon (Anaes.) (Assist.)	tion, thoracotomy or thoracoscopy; and
New		
30753	<b>Fee:</b> \$1,790.65 <b>Benefit:</b> 75% = \$1343.00	
	Oesophagectomy, by any approach, including: (a) gastric reconstruction by abdominal mobilisa (b) anastomosis in the neck or chest Conjoint surgery, principal surgeon (Anaes.) (A	
<b>New</b> 30754	<b>Fee:</b> \$1,790.65 <b>Benefit:</b> 75% = \$1343.00	
<b>New</b> 30755	Oesophagectomy by any approach, including: (a) gastric reconstruction by abdominal mobilisa (b) anastomosis in the neck or chest Conjoint surgery, co-surgeon (Anaes.) (Assist.)	tion, thoracotomy or thoracoscopy; and

T8. SUF	RGICAL OPERATIO	NS	1. GENERAL
	Fee: \$1,343.00	<b>Benefit:</b> 75% = \$1007.25	
		n by fundoplasty, with or without cardiopexy, by any approach, wi rragmatic hiatus, other than a service to which item 30601 applies	
<b>New</b> 30756	Fee: \$906.65	<b>Benefit:</b> 75% = \$680.00	
•••	Vagotomy, with or without gastroenterostomy, pyloroplasty or other drainage procedure (Anaes.) (Assist.)		
<b>New</b> 30760	Fee: \$611.95	<b>Benefit:</b> 75% = \$459.00	
N	wedge excision (wi (a) vagotomy and p	er, control of, by laparoscopy or laparotomy, involving suture of b th or without gastric resection), including either of the following (i pyloroplasty; my (Anaes.) (Assist.)	01
<b>New</b> 30761	Fee: \$789.45	<b>Benefit:</b> 75% = \$592.10	
			pproach, including
<b>New</b> 30762	Fee: \$1,730.05	<b>Benefit:</b> 75% = \$1297.55	
		m or greater in diameter, removal of, by local excision, by endosco red anastomosis, excluding polypectomy, other than a service to w assist.)	
<b>New</b> 30763	Fee: \$702.70	<b>Benefit:</b> 75% = \$527.05	
		er, peritoneum or viscus, complete removal of contents of, with or h omentoplasty or myeloplasty (Anaes.) (Assist.)	without suture of
<b>New</b> 30770	Fee: \$870.25	<b>Benefit:</b> 75% = \$652.70	
	Portal hypertension	, porto-caval, meso-caval or selective spleno-renal shunt for (Anae	es.) (Assist.)
New 30771	Fee: \$1,755.20	<b>Benefit:</b> 75% = \$1316.40	
	Intrahepatic biliary system (Anaes.) (A	bypass of left or right hepatic ductal system by Roux-en-Y loop to ssist.)	peripheral ductal
<b>New</b> 30780	Fee: \$1,461.85	<b>Benefit:</b> 75% = \$1096.40	
		stomosis to stomach, duodenum or small intestine, by endoscopic, with or without the use of endoscopic or intraoperative ultrasound	
<b>New</b> 30790	Fee: \$729.70	<b>Benefit:</b> 75% = \$547.30	
<b>N</b> 7	Pancreatic necrosectomy, by open, laparoscopic or endoscopic approach, excluding aftercare, subsequent procedure (Anaes.) (Assist.)		
<b>New</b> 30791	Fee: \$453.35	<b>Benefit:</b> 75% = \$340.05	
Now	Distal pancreatecto	my with splenectomy, by open or minimally invasive approach (A	naes.) (Assist.)
<b>New</b> 30792	Fee: \$1,242.65	<b>Benefit:</b> 75% = \$932.00	
<b>New</b> 30800	Splenectomy, by op (Anaes.) (Assist.)	pen or minimally invasive approach, other than a service to which i	item 30792 applies

T8. SUF	GICAL OPERATI	ONS	1. GENERAL
	Fee: \$749.40	<b>Benefit:</b> 75% = \$562.05	
	(a) followed by lo	ncreas or duodenum for endocrine tumour, including associated ocal excision of tumour; or tensive exploration, no tumour is found (Anaes.) (Assist.)	d imaging, either:
New 30810	Fee: \$1,193.70	<b>Benefit:</b> 75% = \$895.30	
	Lymph node of ne examination (Ana	eck, biopsy of, by open procedure, if the specimen excised is see.)	ent for pathological
New 30820	Fee: \$191.35	<b>Benefit:</b> 75% = \$143.55 85% = \$162.65	
	utilising horizonta all excised tissue	skin tumour located on the head, neck, genitalia, hand, digits, le al frozen sections with mapping of all excised tissue, and histol by the specialist performing the procedure, if the specialist is re ege of Dermatologists as an approved Mohs surgeon—6 or few	ogical examination of ecognised by the
<b>Fee</b> 31000	(See para TN.8.151 <b>Fee:</b> \$604.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$453.35 85% = \$519.75	
	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.)		
<b>Fee</b> 31001	(See para TN.8.151 <b>Fee:</b> \$755.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$566.60 85% = \$670.75	
	utilising horizonta all excised tissue	skin tumour located on the head, neck, genitalia, hand, digits, le al frozen sections with mapping of all excised tissue, and histol by the specialist performing the procedure, if the specialist is re ege of Dermatologists as an approved Mohs surgeon—13 or m	ogical examination of ecognised by the
Fee         (See para TN.8.151 of explanatory notes to this Categor 31002           Fee:         \$906.65         Benefit:         75% = \$680.00         85%		of explanatory notes to this Category) Benefit: 75% = \$680.00 85% = \$821.95	
	histological exam	skin tumour utilising horizontal frozen sections with mapping of ination of all excised tissue by the specialist performing the pro- he Australasian College of Dermatologists as an approved Moh	ocedure, if the specialist
	Not applicable to	a service performed in association with a service to which item	n 31000 applies (Anaes.)
<b>Fee</b> 31003	(See para TN.8.151 <b>Fee:</b> \$604.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$453.35 85% = \$519.75	
	histological exam	skin tumour utilising horizontal frozen sections with mapping of ination of all excised tissue by the specialist performing the pro- he Australasian College of Dermatologists as an approved Mol e)	ocedure, if the specialist
	Not applicable to	a service performed in association with a service to which item	n 31001 applies (Anaes.)
<b>Fee</b> 31004	(See para TN.8.151 <b>Fee:</b> \$755.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$566.60 85% = \$670.75	
<b>Fee</b> 31005		skin tumour utilising horizontal frozen sections with mapping of ination of all excised tissue by the specialist performing the pro-	

T8. SUR	GICAL OPERATIONS 1. GENERA	۹L
	is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 or mor sections	e
	Not applicable to a service performed in association with a service to which item 31002 applies (Anaes	s.)
	(See para TN.8.151 of explanatory notes to this Category)         Fee: \$906.65       Benefit: 75% = \$680.00       85% = \$821.95	
	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 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	ł
Fee	(c) the specimen excised is sent for histological examination (Anaes.)	
31206	<b>Fee:</b> \$99.35 <b>Benefit:</b> 75% = \$74.55 85% = \$84.45	
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:	
	(a) the lesion size is more than 10 mm, but not more than 20 mm, in diameter; and	
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and	ł
Fee	(c) the specimen excised is sent for histological examination (Anaes.)	
31211	<b>Fee:</b> \$128.10 <b>Benefit:</b> 75% = \$96.10 85% = \$108.90	
	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	1
Fee	(c) the specimen excised is sent for histological examination (Anaes.)	
31216	<b>Fee:</b> \$149.40 <b>Benefit:</b> 75% = \$112.05 85% = \$127.00	
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if:	l
	(a) the size of each lesion is not more than 10 mm in diameter; and	
	(b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and	
<b>D</b>	(c) all of the specimens excised are sent for histological examination (Anaes.)	
Fee 31220	<b>Fee:</b> \$223.25 <b>Benefit:</b> 75% = \$167.45 85% = \$189.80	
	Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation) removal of 4 to 10 lesions, if:	,
<b>Fee</b> 31221	(a) the size of each lesion is not more than 10 mm in diameter; and	

T8. SUF	RGICAL OPERATIONS	1. GENERAL	
	(b) each removal is from a mucous membrane by surgical excision (other than by	shave excision); and	
	(c) each site of excision is closed by suture; and		
	(d) all of the specimens excised are sent for histological examination (Anaes.)		
	<b>Fee:</b> \$223.25 <b>Benefit:</b> 75% = \$167.45 85% = \$189.80		
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts (other than scars removed during the surgical approach at an operation), removal of relesions, 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 b (other than by	by surgical 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.)		
Fee 31225	<b>Fee:</b> \$396.75 <b>Benefit:</b> 75% = \$297.60 85% = \$337.25		
	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of HIDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE (excision from face or neck) (Anaes.)		
<b>Fee</b> 31245	(See para TN.8.23 of explanatory notes to this Category) <b>Fee:</b> \$383.90 <b>Benefit:</b> 75% = \$287.95 85% = \$326.35		
	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of the specimen excised is sent for histological confirmation of diagnosis (Anaes.)	f body surface where	
Fee 31250	<b>Fee:</b> \$383.90 <b>Benefit:</b> 75% = \$287.95 85% = \$326.35		
	Muscle, bone or cartilage, excision of one or more of, if clinically indicated, and if:		
	(a) the specimen excised is sent for histological confirmation; and		
	(b) a malignant tumour of skin covered by item 31000, 31001, 31002, 31003, 31004, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371, 31372, 31373, 31374, 31 excised (Anaes.)		
31340	Derived Fee: 75% of the fee for excision of malignant tumour		
	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and <u>50mm or</u> <u>more in diameter</u> , or is sub-fascial, <i>where the specimen is sent for histological confirmation of diagnosis</i> (Anaes.)		
<b>Fee</b> 31345	<b>Fee:</b> \$219.50 <b>Benefit:</b> 75% = \$164.65 85% = \$186.60		
	Liposuction (suction assisted lipolysis) to one regional area for contour problems of arm or thigh fat because of repeated insulin injections, if:	abdominal, upper	
	(a) the lesion is subcutaneous; and		
<b>Fee</b> 31346	(b) the lesion is 50 mm or more in diameter; and		

T8. SUR	RGICAL OPERATIONS	1. GENERAL
	(c) photographic and/or diagnostic imaging evidence demonstrating the need for this documented in the patient notes (Anaes.)	service is
	(See para TN.8.101 of explanatory notes to this Category) <b>Fee:</b> \$219.50 <b>Benefit:</b> 75% = \$164.65 85% = \$186.60	
Amend	Benign tumour of soft tissue (other than tumours of skin, cartilage and bone, simple litem 31345 and lipomata), removal of, by surgical excision, on a patient 10 years of a specimen excised is sent for histological confirmation of diagnosis, other than a service item in this Group applies (Anaes.) (Assist.)	ge or over, if the
Fee 31350	<b>Fee:</b> \$450.90 <b>Benefit:</b> 75% = \$338.20 85% = \$383.30	
Fee	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage ar by surgical excision, where <i>histological proof of malignancy has been obtained</i> , not be which another item in this Group applies (Anaes.) (Assist.)	
31355	<b>Fee:</b> \$743.45 <b>Benefit:</b> 75% = \$557.60 85% = \$658.75	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 313 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	72, 31373, 31374,
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or fr area; and	om a contiguous
	(b) the necessary excision diameter is less than 6 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
<b>Fee</b> 31356	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$230.30 <b>Benefit:</b> 75% = \$172.75 85% = \$195.80	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic including a cyst, ulcer or scar (other than a scar removed during the surgical approach surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or fr area; and	om a contiguous
	(b) the necessary excision diameter is less than 6 mm; and	
	(c) the excised specimen is sent for histological examination;	
	not in association with item 45201 (Anaes.)	
<b>Fee</b> 31357	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$114.10 <b>Benefit:</b> 75% = \$85.60 85% = \$97.00	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 313 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	72, 31373, 31374,
<b>Fee</b> 31358	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or fr area; and	om a contiguous

T8. SUF	GICAL OPERATIONS	1. GENERAL			
	(b) the necessary excision diameter is 6 mm or more; and				
	(c) the excised specimen is sent for histological examination; and				
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)				
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category)           Fee: \$281.85         Benefit: 75% = \$211.40         85% = \$239.60				
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 3137 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 (th	e applicable site); and			
	(b) the necessary excision area is at least one third of the surface area of the appli	icable 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.)				
<b>Fee</b> 31359	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$343.55 <b>Benefit:</b> 75% = \$257.70				
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrhei including a cyst, ulcer or scar (other than a scar removed during the surgical approa surgical excision (other than by shave excision) and repair of, if:				
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or area; and	from a contiguous			
	(b) the necessary excision diameter is 6 mm or more; and				
	(c) the excised specimen is sent for histological examination (Anaes.)				
<b>Fee</b> 31360	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$174.85 <b>Benefit:</b> 75% = \$131.15 85% = \$148.65				
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 3 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 low including, the	er limb (distal to, and			
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and				
	(b) the necessary excision diameter is less than 14 mm; and				
	(c) the excised specimen is sent for histological examination; and				
	(d) malignancy is confirmed from the excised specimen or previous biopsy;				
	not in association with item 45201 (Anaes.)				
<b>Fee</b> 31361	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$194.30 <b>Benefit:</b> 75% = \$145.75 85% = \$165.20				
Fee	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrhei	ic keratoses),			

T8. SUF	RGICAL OPERATIONS 1. GEN	NERAL
31362	including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an opera surgical excision (other than by shave excision) and repair of, if:	tion),
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal including, the	to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is less than 14 mm; and	
	(c) the excised specimen is sent for histological examination;	
	not in association with item 45201 (Anaes.)	
	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$139.35 <b>Benefit:</b> 75% = \$104.55 85% = \$118.45	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 3 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	31374,
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal including, the	to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is 14 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
<b>Fee</b> 31363	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$254.15 <b>Benefit:</b> 75% = \$190.65 85% = \$216.05	
	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 opera surgical excision (other than by shave excision) and repair of, if:	tion),
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal including, the	to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is 14 mm or more; and	
	(c) the excised specimen is sent for histological examination (Anaes.)	
<b>Fee</b> 31364	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$174.85 <b>Benefit:</b> 75% = \$131.15 85% = \$148.65	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 3 or 31373), surgical excision (other than by shave excision) and repair of, if:	31372
	(a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31363; and	1361 or
<b>Fee</b> 31365	(b) the necessary excision diameter is less than 15 mm; and	

T8. SURC	GICAL OPERATIONS 1. G	ENERAL			
	(c) the excised specimen is sent for histological examination; and				
	(d) malignancy is confirmed from the excised specimen or previous biopsy;				
	not in association with item 45201 (Anaes.)				
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$164.70 <b>Benefit:</b> 75% = \$123.55 85% = \$140.00				
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratose including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an or 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 and	or 31364;			
	(b) the necessary excision diameter is less than 15 mm; and				
	(c) the excised specimen is sent for histological examination;				
	not in association with item 45201 (Anaes.)				
<b>Fee</b> 31366	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$99.35 <b>Benefit:</b> 75% = \$74.55 85% = \$84.45				
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	3, 31374,			
	(a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359 31363; and	, 31361 or			
	(b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and				
	(c) the excised specimen is sent for histological examination; and				
	(d) malignancy is confirmed from the excised specimen or previous biopsy;				
	not in association with item 45201 (Anaes.)				
<b>Fee</b> 31367	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$222.25 <b>Benefit:</b> 75% = \$166.70 85% = \$188.95				
	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 op 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 and	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.)				
<b>Fee</b> 31368	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$130.60 <b>Benefit:</b> 75% = \$97.95 85% = \$111.05				
Fee	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31372	3, 31374,			

T8. SUF	RGICAL OPERATIONS	1. GENERAL
31369	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, 313 31363; and	58, 31359, 31361 or
	(b) the necessary excision diameter is more than 30 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anae	s.)
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$255.90 <b>Benefit:</b> 75% = \$191.95 85% = \$217.55	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic including a cyst, ulcer or scar (other than a scar removed during the surgical approac surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from any part of the body not covered by item 31357, 313 and	60, 31362 or 31364;
	(b) the necessary excision diameter is more than 30 mm; and	
	(c) the excised specimen is sent for histological examination (Anaes.)	
<b>Fee</b> 31370	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$149.40 <b>Benefit:</b> 75% = \$112.05 85% = \$127.00	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour or carcinoma of skin, definitive surgical excision (other than by shave excision) and rep	
	(a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or area; and	from a contiguous
	(b) the necessary excision diameter is 6 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes	5.)
<b>Fee</b> 31371	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$371.45 <b>Benefit:</b> 75% = \$278.60 85% = \$315.75	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour or carcinoma of skin, definitive surgical excision (other than by shave excision) and rep	
	(a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal low 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;	
<b>Fee</b> 31372	not in association with item 45201 (Anaes.)	

T8. SUF	RGICAL OPERATIONS 1. GENERA	۱L			
	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$321.20 <b>Benefit:</b> 75% = \$240.90 85% = \$273.05				
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel ce carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:	211			
	(a) the tumour 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.)				
<b>Fee</b> 31373	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$371.25 <b>Benefit:</b> 75% = \$278.45 85% = \$315.60				
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel ce carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:	211			
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372 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.)				
<b>Fee</b> 31374	(See para TN.8.125, TN.1.21 of explanatory notes to this Category) <b>Fee:</b> \$293.30 <b>Benefit:</b> 75% = \$220.00 85% = \$249.35				
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel ce carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:	÷11			
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; 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.)				
<b>Fee</b> 31375	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$315.65 <b>Benefit:</b> 75% = \$236.75 85% = \$268.35				
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel co carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:	÷11			
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and				
<b>Fee</b> 31376	(b) the necessary excision diameter is more than 30 mm; and				

T8. SUR	RGICAL OPERATIONS	1. GENERAL
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous b	piopsy (Anaes.)
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$365.85 <b>Benefit:</b> 75% = \$274.40 85% = \$311.00	
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to a (excluding tumour of the lip), excision of, where histological confirmatiobtained (Anaes.) (Assist.)	
Fee 31400	<b>Fee:</b> \$271.65 <b>Benefit:</b> 75% = \$203.75 85% = \$230.95	
Fee	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more the including 40mm in diameter (excluding tumour of the lip), excision of, of malignancy has been obtained (Anaes.) (Assist.)	
31403	Fee: \$313.55         Benefit: 75% = \$235.20	
Fee	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more the (excluding tumour of the lip), excision of, where histological confirmation obtained (Anaes.) (Assist.)	
31406	Fee: \$522.50         Benefit: 75% = \$391.90         85% = \$444.15	
<b>Fee</b> 31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (A Fee: \$1,623.40 Benefit: 75% = \$1217.55	Anaes.) (Assist.)
<b>Fee</b> 31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, 6(Anaes.) (Assist.)Fee: \$1,999.65Benefit: 75% = \$1499.75	excision of, by cervical approach
<b>Amend</b> <b>Fee</b> 31423	Lymph nodes of neck, selective dissection of one or 2 lymph node leveltissue and lymph nodes from one side of the neck, on a patient 10 years(See para TN.8.24 of explanatory notes to this Category)Fee: \$418.05Benefit: 75% = \$313.5585% = \$355.35	ls involving removal of soft of age or over (Anaes.) (Assist.)
	LYMPH NODES OF NECK, selective dissection of 3 lymph node leve tissue and lymph nodes from one side of the neck (Anaes.) (Assist.)	ls involving removal of soft
Fee 31426	(See para TN.8.24 of explanatory notes to this Category) <b>Fee:</b> \$836.00 <b>Benefit:</b> 75% = \$627.00	
	LYMPH NODES OF NECK, selective dissection of 4 lymph node level preservation of one or more of: internal jugular vein, sternocleido-master nerve (Anaes.) (Assist.)	
<b>Fee</b> 31429	(See para TN.8.24 of explanatory notes to this Category) <b>Fee:</b> \$1,302.85 <b>Benefit:</b> 75% = \$977.15	
	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II dissections) (Anaes.) (Assist.)	I and III (bilateral supraomohyoid
<b>Fee</b> 31432	(See para TN.8.24 of explanatory notes to this Category) <b>Fee:</b> \$1,393.45 <b>Benefit:</b> 75% = \$1045.10	
<b>Fee</b> 31435	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph neck (Anaes.) (Assist.)	node levels on one side of the

T8. SUR	GICAL OPERATIO	DNS	1. GENERAL
	(See para TN.8.24 o <b>Fee:</b> \$1,024.20	f explanatory notes to this Category) Benefit: 75% = \$768.15	
		OF NECK, comprehensive dissection of all 5 lymph node levels on ation of one or more of: internal jugular vein, sternocleido-mastoid a Anaes.) (Assist.)	
<b>Fee</b> 31438	(See para TN.8.24 o <b>Fee:</b> \$1,623.40	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$1217.55	
Amend Fee		parotomy with drainage of bile, as an independent procedure (H) (A	anaes.) (Assist.)
31454	Fee: \$586.15	<b>Benefit:</b> 75% = \$439.65	
T		and insertion of nasogastric or nasoenteral feeding tube, where blin ailed or is inappropriate due to the patient's medical condition (Anae	
<b>Fee</b> 31456	Fee: \$255.55	<b>Benefit:</b> 75% = \$191.70	
Fee	feeding tube has f	and insertion of nasogastric or nasoenteral feeding tube, where blin ailed or is inappropriate due to the patient's medical condition, and v ation is clinically indicated (Anaes.)	
31458	Fee: \$306.60	<b>Benefit:</b> 75% = \$229.95	
	PERCUTANEOU services (Anaes.)	S GASTROSTOMY TUBE, jejunal extension to, including any ass (Assist.)	ociated imaging
Fee 31460	<b>Fee:</b> \$371.45	<b>Benefit:</b> 75% = \$278.60	
51400		EDING JEJUNOSTOMY performed in conjunction with major upp	er gastro-intestinal
<b>Fee</b> 31462	<b>Fee:</b> \$542.40	<b>Benefit:</b> 75% = \$406.80	
		PERATION BY FUNDOPLASTY, via abdominal or thoracic appro the diaphragmatic hiatus, revision procedure, by laparoscopy or op	
<b>Fee</b> 31466	(See para TN.8.19 o <b>Fee:</b> \$1,359.90	f explanatory notes to this Category) Benefit: 75% = \$1019.95	
Amend	of hiatus, with or	hiatus hernia, repair of, with complete reduction of hernia, resection without fundoplication, other than a service associated with a servic oplies (Anaes.) (Assist.)	
Fee 31468	Fee: \$1,494.05	<b>Benefit:</b> 75% = \$1120.55	
Amend Fee	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-y loop to provide biliary drainage or bypass, other than a service associated with a service to which item 30584 applies (Anaes.) (Assist.)		
31472	Fee: \$1,399.80	<b>Benefit:</b> 75% = \$1049.85	
		N LESION up to and including 50mm in diameter, including simple ibrocystic disease, open surgical biopsy or excision of, with or with	
<b>Fee</b> 31500	(See para TN.8.25 o <b>Fee:</b> \$270.55	f explanatory notes to this Category) Benefit: $75\% = $202.95$ $85\% = $230.00$	

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	BREAST, BENIGN LESION more than 50mm in diameter	er, excision of (Anaes.) (Assist.)
<b>Fee</b> 31503	(See para TN.8.25 of explanatory notes to this Category)Fee: $$360.80$ Benefit: $75\% = $270.60$ $85\% = $306.$	70
	BREAST, ABNORMALITY detected by mammography of localisation procedure is performed, excision biopsy of (A	
<b>Fee</b> 31506	(See para TN.8.25 of explanatory notes to this Category) <b>Fee:</b> \$405.90 <b>Benefit:</b> 75% = \$304.45	
	BREAST, MALIGNANT TUMOUR, open surgical biops (Anaes.)	y of, with or without frozen section histology
<b>Fee</b> 31509	(See para TN.8.25 of explanatory notes to this Category)Fee: $\$360.80$ Benefit: $75\% = \$270.60$ $85\% = \$306$	70
Fac	BREAST, MALIGNANT TUMOUR, complete local exci histology (Anaes.) (Assist.)	ision of, with or without frozen section
Fee 31512	<b>Fee:</b> \$676.50 <b>Benefit:</b> 75% = \$507.40	
	BREAST, TUMOUR SITE, re-excision of following oper tumour (Anaes.) (Assist.)	n biopsy or incomplete excision of malignant
<b>Fee</b> 31515	(See para TN.8.25 of explanatory notes to this Category) Fee: \$453.85 Benefit: 75% = \$340.40	
	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology when targeted intraoperative radiation therapy (using an Intrabeam® or Xoft® Axxer device) is performed concurrently, if the patient satisfies the requirements mentioned in paragra (g) of item 15900	
Fee	Applicable only once per breast per lifetime (H) (Anaes.)	(Assist.)
31516	<b>Fee:</b> \$902.10 <b>Benefit:</b> 75% = \$676.60	
Fee	BREAST, total mastectomy (H) (Anaes.) (Assist.)	
31519	<b>Fee:</b> \$765.90 <b>Benefit:</b> 75% = \$574.45	
	BREAST, subcutaneous mastectomy (H) (Anaes.) (Assist.	.)
<b>Fee</b> 31524	<b>Fee:</b> \$1,082.40 <b>Benefit:</b> 75% = \$811.80	
	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.)	
Fee 31525	<b>Fee:</b> \$541.05 <b>Benefit:</b> 75% = \$405.80	
	Breast, biopsy of solid tumour or tissue of, using a vacuum guidance, for histological examination, if imaging has den (a) microcalcification of lesion; or (b) impalpable lesion less than one cm in diameter; including pre-operative localisation of lesion, if performed to which item 31548 applies	nonstrated:
Fee 31530	<b>Fee:</b> \$619.85 <b>Benefit:</b> 75% = \$464.90 85% = \$535.	15
<b>Fee</b> 31533	FINE NEEDLE ASPIRATION of an impalpable breast less imaging guided - but not including imaging (Anaes.)	

T8. SUF	RGICAL OPERATIONS	1. GENERAL	
	(See para TN.8.26 of explanatory notes to this Category) <b>Fee:</b> \$143.50 <b>Benefit:</b> 75% = \$107.65 85% = \$122.00		
Faa	Breast, preoperative localisation of lesion of, by hookwire or similar dev imaging techniques, but not including imaging (Anaes.) (Anaes.)	ice, using interventional	
<b>Fee</b> 31536	<b>Fee:</b> \$197.10 <b>Benefit:</b> 75% = \$147.85 85% = \$167.55		
	Breast, biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination, other than a service associated with a service to which item 31530 applies (Anaes.) (Anaes.)		
<b>Fee</b> 31548	(See para TN.8.26 of explanatory notes to this Category) <b>Fee:</b> \$208.10 <b>Benefit:</b> 75% = \$156.10 85% = \$176.90		
	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDI granulomatous mastitis or similar, exploration and drainage of when unc of a hospital, excluding aftercare (Anaes.)		
Fee 31551	<b>Fee:</b> \$225.50 <b>Benefit:</b> 75% = \$169.15		
	BREAST, microdochotomy of, for benign or malignant condition (Anae	s.) (Assist.)	
<b>Fee</b> 31554	<b>Fee:</b> \$451.05 <b>Benefit:</b> 75% = \$338.30		
51554	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.	) (Assist)	
<b>Fee</b> 31557	Fee:         \$360.80         Benefit:         75% = \$270.60         85% = \$306.70	, (199191.)	
	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.)		
<b>Fee</b> 31560	Fee:         \$360.80         Benefit:         75% = \$270.60         85% = \$306.70           Extended Medicare Safety Net Cap:         \$288.65		
Fee	INVERTED NIPPLE, surgical eversion of (Anaes.)		
31563	Fee: \$270.25         Benefit: 75% = \$202.70         85% = \$229.75		
Fee	ACCESSORY NIPPLE, excision of (Anaes.)		
<b>Fee</b> 31566	<b>Fee:</b> \$135.25 <b>Benefit:</b> 75% = \$101.45 85% = \$115.00		
	Removal of adjustable gastric band (Anaes.) (Assist.)		
<b>New</b> 31585	<b>Fee:</b> \$865.85 <b>Benefit:</b> 75% = \$649.40		
	BARIATRIC		
	Adjustable gastric band, placement of, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)		
<b>Fee</b> 31569	(See para TN.8.29 of explanatory notes to this Category) <b>Fee:</b> \$884.00 <b>Benefit:</b> 75% = \$663.00		
	Gastric bypass by Roux-en-Y including associated anastomoses, with or minutes or less, for a patient with clinically severe obesity not being asso item 30515 applies (Anaes.) (Assist.)	1 0	
<b>Fee</b> 31572	(See para TN.8.29 of explanatory notes to this Category) <b>Fee:</b> \$1,087.80 <b>Benefit:</b> 75% = \$815.85		
<b>Fee</b> 31575	Sleeve gastrectomy, with or without crural repair taking 45 minutes or le severe obesity (Anaes.) (Assist.)	ess, for a patient with clinically	

T8. SUF		DNS	1. GENERAL
	(See para TN.8.29 of <b>Fee:</b> \$884.00	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$663.00	
		uding by gastric plication), with or without crural repair taking 4 cally severe obesity (Anaes.) (Assist.)	5 minutes or less, for
<b>Fee</b> 31578	(See para TN.8.29 of <b>Fee:</b> \$884.00	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$663.00	
	• • •	biliopancreatic diversion with or without duodenal switch includ with or without crural repair taking 45 minutes or less, for a patie aes.) (Assist.)	
<b>Fee</b> 31581	(See para TN.8.29 of <b>Fee:</b> \$1,087.80	f explanatory notes to this Category) Benefit: 75% = \$815.85	
	a) the previous pro (i) placement of ac (ii) gastric bypass; (iii) sleeve gastrect	f previous bariatric procedure, including revision or conversion, cedure involved any of the following: ljustable gastric banding; tomy; excluding gastric plication);	if:
Amend	<ul><li>(v) biliopancreatic</li><li>(b) any of items 31 other than a servic</li></ul>	diversion; and 569 to 31581 applied to the previous procedure e associated with a service to which item 31585 applies (Anaes.)	(Assist.)
<b>Fee</b> 31584	(See para TN.8.30 of <b>Fee:</b> \$1,601.50	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$1201.15	
<b>Fee</b> 31587	Adjustment of gas <b>Fee:</b> \$101.90	tric band as an independent procedure including any associated c Benefit: 75% = \$76.45 85% = \$86.65	consultation
	Adjustment of gas	tric band reservoir, repair, revision or replacement of (Anaes.) (A	Assist.)
Fee 31590	Fee: \$261.95	<b>Benefit:</b> 75% = \$196.50 85% = \$222.70	
T8. SUF		DNS	2. COLORECTAL
	Group T8. Surgica	al Operations	
		Subgroup 2. Colorectal	
F		NE, resection of, without anastomosis, including right hemicoleo a) (Anaes.) (Assist.)	ctomy (including
Fee 32000	Fee: \$1,073.10	<b>Benefit:</b> 75% = \$804.85	
Fee	LARGE INTESTI	NE, resection of, with anastomosis, including right hemicolector	ny (Anaes.) (Assist.)
32003	Fee: \$1,122.50	<b>Benefit:</b> 75% = \$841.90	
Eac		NE, subtotal colectomy (resection of right colon, transverse colo is, not being a service associated with a service to which item 32 aes.) (Assist.)	
Fee 32004	Fee: \$1,197.00	<b>Benefit:</b> 75% = \$897.75	
<b>Fee</b> 32005		NE, subtotal colectomy (resection of right colon, transverse colo not being a service associated with a service to which item 3200	

T8. SUF		ONS 2. COLORECTAL
	32006 applies (Ar	naes.) (Assist.)
	Fee: \$1,352.20	<b>Benefit:</b> 75% = \$1014.15
-	LEFT HEMICOL stoma) (Anaes.) (A	ECTOMY, including the descending and sigmoid colon (including formation of Assist.)
Fee 32006	Fee: \$1,197.00	<b>Benefit:</b> 75% = \$897.75
Fee		TOMY AND ILEOSTOMY (Anaes.) (Assist.)
32009	<b>Fee:</b> \$1,419.90	Benefit: 75% = \$1064.95
<b>Fee</b> 32012	<b>Fee:</b> \$1,568.45	COMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) Benefit: 75% = \$1176.35
		TOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.)
Fee 32015	Fee: \$1,927.60	<b>Benefit:</b> 75% = \$1445.70
		COMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED S OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.)
Fee 32018	Fee: \$1,634.55	<b>Benefit:</b> 75% = \$1225.95
		TOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED S OPERATION; PERINEAL RESECTION (Assist.)
Fee 32021	Fee: \$586.15	<b>Benefit:</b> 75% = \$439.65
		ion of stent or stents for large bowel obstruction, stricture or stenosis, including any image intensification, where the obstruction is due to:
	a) a pre-dia	agnosed colorectal cancer, or cancer of an organ adjacent to the bowel; or
	b) an unkn	own diagnosis (Anaes.)
Fee 32023	(See para TN.8.17 c <b>Fee:</b> \$577.85	of explanatory notes to this Category) Benefit: 75% = \$433.40
	ANASTOMOSIS	RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL (of the rectum) greater than 10 centimetres from the anal verge excluding resection of ne not being a service associated with a service to which item 32103, 32104 or 32106 Assist.)
Fee 32024	Fee: \$1,419.90	<b>Benefit:</b> 75% = \$1064.95
	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.)	
Fee 32025	Fee: \$1,899.25	<b>Benefit:</b> 75% = \$1424.45
		A LOW RESTORATIVE RESECTION, with or without covering stoma, where the ed in the anorectal region and is 6cm or less from the anal verge (Anaes.) (Assist.)
<b>Fee</b> 32026	Fee: \$2,045.30	<b>Benefit:</b> 75% = \$1534.00
Fee 32028	RECTUM, LOW	OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal

T8. SUF	SURGICAL OPERATIONS 2. COLOR		
	anastomosis, with	h or without covering stoma (Anaes.) (Assist.)	
	Fee: \$2,191.55	<b>Benefit:</b> 75% = \$1643.70	
-		ERVOIR, construction of, being a service associated with a service to which any other roup applies (Anaes.) (Assist.)	
Fee 32029	Fee: \$438.25	<b>Benefit:</b> 75% = \$328.70	
<b>Fee</b> 32030	<b>RECTOSIGMOI</b> <b>Fee:</b> \$1,073.10	DECTOMY (Hartmann's operation) (Anaes.) (Assist.) Benefit: 75% = \$804.85	
		OF BOWEL following Hartmann's or similar operation, including dismantling of the	
Fee 32033	Fee: \$1,568.45	<b>Benefit:</b> 75% = \$1176.35	
<b>F</b>	SACROCOCCY	GEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.)	
Fee 32036	Fee: \$1,989.30	<b>Benefit:</b> 75% = \$1492.00	
-	RECTUM AND	ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.)	
Fee 32039	Fee: \$1,597.25	<b>Benefit:</b> 75% = \$1197.95	
T		ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS odominal resection (Anaes.) (Assist.)	
Fee 32042	Fee: \$1,345.55	<b>Benefit:</b> 75% = \$1009.20	
		ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS erineal resection (Assist.)	
Fee 32045	Fee: \$503.60	<b>Benefit:</b> 75% = \$377.70	
		NUS, abdomino-perineal resection of, combined synchronous operation - perineal he perineal surgeon also provides assistance to the abdominal surgeon (Assist.)	
Fee 32046	Fee: \$778.20	<b>Benefit:</b> 75% = \$583.65	
	PERINEAL PROCTECTOMY (Anaes.) (Assist.)		
Fee 32047	Fee: \$906.65	<b>Benefit:</b> 75% = \$680.00	
		TOMY with excision of rectum and ileoanal anastomosis with formation of ileal without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.)	
Fee 32051	Fee: \$2,410.45	<b>Benefit:</b> 75% = \$1807.85	
	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)		
Fee 32054	<b>Fee:</b> \$2,212.35	<b>Benefit:</b> 75% = \$1659.30	
	TOTAL COLEC	TOMY with excision of rectum and ileoanal anastomosis with formation of ileal nt surgery, perineal surgeon (Assist.)	
Fee 32057	Fee: \$586.15	<b>Benefit:</b> 75% = \$439.65	
<b>Fee</b> 32060		LOSURE with rectal resection and mucosectomy and ileoanal anastomosis with l reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.) (Assist.)	

T8. SUF	JRGICAL OPERATIONS		2. COLORECTAL	
	Fee: \$2,410.45	<b>Benefit:</b> 75% = \$1807.85		
<b>F</b>	formation of ileal	OSURE with rectal resection and mucosectom reservoir, with or without temporary loop ileos g aftercare) (Anaes.) (Assist.)		
Fee 32063	Fee: \$2,212.35	<b>Benefit:</b> 75% = \$1659.30		
		OSURE with rectal resection and mucosectom reservoir, with or without temporary loop ileos		
Fee 32066	Fee: \$586.15	<b>Benefit:</b> 75% = \$439.65		
	ILEOSTOMY RE where appropriate	SERVOIR, continent type, creation of, includi (Anaes.)	ng conversion of existing ileostomy	
Fee 32069	Fee: \$1,783.05	<b>Benefit:</b> 75% = \$1337.30		
	SIGMOIDOSCO	PIC EXAMINATION (with rigid sigmoidosco	pe), with or without biopsy	
Fee 32072	<b>Fee:</b> \$49.80	<b>Benefit:</b> 75% = \$37.35 85% = \$42.35		
	SIGMOIDOSCO	PIC EXAMINATION (with rigid sigmoidosco) with or without biopsy, not being a service ass		
Fee 32075	Fee: \$78.10	<b>Benefit:</b> 75% = \$58.60 85% = \$66.40		
	Sigmoidoscopy or colonoscopy up to the hepatic flexure, with or without biopsy, other than associated with a service to which any of items 32222 to 32228 applies.			
	(Anaes.)			
<b>Fee</b> 32084	(See para TN.8.17, <b>'</b> <b>Fee:</b> \$115.90	TN.8.134 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$86.95 85% = \$98.55		
	Endoscopic examination of the colon up to the hepatic flexure by sigmoidoscopy or colonoscopy for the removal of one or more polyps, other than a service associated with a service to which any of items 32222 to 32228 applies (Anaes.)			
	(Anaes.)			
<b>Fee</b> 32087	(See para TN.8.17, <b>Fee:</b> \$213.00	TN.8.134 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$159.75 85% = \$181.05		
	ENDOSCOPIC D	ILATATION OF COLORECTAL STRICTUR	RES including colonoscopy (Anaes.)	
<b>Fee</b> 32094	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$574.20 <b>Benefit:</b> 75% = \$430.65			
	ENDOSCOPIC E or without biopsie	XAMINATION of SMALL BOWEL with flex s (Anaes.)	kible endoscope passed by stoma, with	
<b>Fee</b> 32095	(See para TN.8.17 c <b>Fee:</b> \$133.00	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$99.75 85% = \$113.05		
<b>Fee</b> 32096		Y, full thickness, under general anaesthesia, or e undertaken in a hospital (Anaes.) (Assist.)	under epidural or spinal (intrathecal)	

T8. SUF	RGICAL OPERAT	IONS	2. COLORECTAL
	Fee: \$267.35	<b>Benefit:</b> 75% = \$200.55	
_	RECTAL TUMO (Assist.)	DUR of 5 centimetres or less in diameter, per anal s	submucosal excision of (Anaes.)
Fee 32099	Fee: \$346.75	<b>Benefit:</b> 75% = \$260.10	
Ess	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.)		
Fee 32102	Fee: \$660.40	<b>Benefit:</b> 75% = \$495.30	
	either 3 dimensio during colonosco	DUR, of less than 4 cm in diameter, per anal excision onal or 2 dimensional optic viewing systems, if rem opy or by local excision, other than a service associ 2104 or 32106 applies (Anaes.) (Assist.)	noval is unable to be performed
<b>Fee</b> 32103	(See para TN.8.31 <b>Fee:</b> \$803.55	, TN.8.17 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$602.70	
	incorporating eit performed during	DUR, of 4 cm or greater in diameter, per anal excis her 3 dimensional or 2 dimensional optic viewing s g colonoscopy or by local excision, other than a ser 4, 32025, 32103 or 32106 applies (Anaes.) (Assist	systems, if removal is unable to be rvice associated with a service to
<b>Fee</b> 32104	(See para TN.8.31 <b>Fee:</b> \$1,040.20	, TN.8.17 of explanatory notes to this Category) Benefit: 75% = \$780.15	
<b>Fee</b> 32105		CARCINOMA per anal full thickness excision of (	(Anaes.) (Assist.)
	Fee: \$503.60         Benefit: 75% = \$377.70         85% = \$428.10           ANTEROLATERAL INTRAPERITONEAL RECTAL TUMOUR, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if remova unable to be performed during colonoscopy and if removal requires dissection within the periton cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 3210 applies (Anaes.) (Assist.)		tic viewing systems, if removal is s dissection within the peritoneal
<b>Fee</b> 32106	(See para TN.8.31 <b>Fee:</b> \$1,419.90	, TN.8.17 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$1064.95 85% = \$1335.20	
		OUR, transsphincteric excision of (Kraske or simila	ar operation) (Anaes.) (Assist.)
Fee 32108	Fee: \$1,040.20	<b>Benefit:</b> 75% = \$780.15	
	RECTAL PROL	APSE Delorme procedure for (Anaes.) (Assist.)	
Fee 32111	Fee: \$660.40	<b>Benefit:</b> 75% = \$495.30	
	RECTAL PROL	APSE, perineal recto-sigmoidectomy for (Anaes.)	(Assist.)
Fee 32112	Fee: \$803.55	<b>Benefit:</b> 75% = \$602.70	
-		CTURE, per anal release of (Anaes.)	
Fee 32114	Fee: \$181.50	<b>Benefit:</b> 75% = \$136.15 85% = \$154.30	
22117		CTURE, dilatation of (Anaes.)	
Fee 32115	Fee: \$132.05	<b>Benefit:</b> 75% = \$99.05	
Fee		APSE, abdominal rectopexy of (Anaes.) (Assist.)	

T8. SUF	SURGICAL OPERATIONS 2. COLOR		
	Fee: \$1,040.20	<b>Benefit:</b> 75% = \$780.15	
	RECTAL PROLA	PSE, perineal repair of (Anaes.) (Assist.)	
Fee 32120	Fee: \$267.35	<b>Benefit:</b> 75% = \$200.55	
	ANAL STRICTURE, anoplasty for (Anaes.) (Assist.)		
<b>Fee</b> 32123	Fee: \$346.75	<b>Benefit:</b> 75% = \$260.10 85% = \$294.75	
	ANAL INCONTI	NENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.)	
Fee 32126	Fee: \$503.60	<b>Benefit:</b> 75% = \$377.70	
	ANAL SPHINCT	ER, direct repair of (Anaes.) (Assist.)	
Fee 32129	Fee: \$660.40	<b>Benefit:</b> 75% = \$495.30	
	RECTOCELE, tra	insanal repair of rectocele (Anaes.) (Assist.)	
Fee 32131	<b>Fee:</b> \$555.25	<b>Benefit:</b> 75% = \$416.45	
52151		DS OR RECTAL PROLAPSE sclerotherapy for (Anaes.)	
Fee 32132	<b>Fee:</b> \$46.90	<b>Benefit:</b> 75% = \$35.20 85% = \$39.90	
52152		OS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy,	
		ra red therapy for (Anaes.)	
Fee 32135	Fee: \$70.30	<b>Benefit:</b> 75% = \$52.75 85% = \$59.80	
02100		DECTOMY including excision of anal skin tags when performed (Anaes.)	
Fee			
32138	Fee: \$382.65	<b>Benefit:</b> 75% = \$287.00 85% = \$325.30	
		DECTOMY involving third or fourth degree haemorrhoids, including excision of anal rformed (Anaes.) (Assist.)	
Fee 32139	Fee: \$382.65	<b>Benefit:</b> 75% = \$287.00	
	ANAL SKIN TAO	GS or ANAL POLYPS, excision of 1 or more of (Anaes.)	
Fee 32142	Fee: \$70.30	<b>Benefit:</b> 75% = \$52.75 85% = \$59.80	
52112		GS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of	
Fee			
32145	Fee: \$140.50	Benefit: 75% = \$105.40	
Fee	PERIANAL IHR	OMBOSIS, incision of (Anaes.)	
32147	Fee: \$46.90	<b>Benefit:</b> 75% = \$35.20 85% = \$39.90	
	OPERATION FOR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.)		
Fee 32150	Fee: \$267.35	<b>Benefit:</b> 75% = \$200.55 85% = \$227.25	
		FION OF, under general anaesthesia, with or without disimpaction of faeces, not being ed with a service to which another item in this Group applies (Anaes.)	
Fee 32153	Fee: \$72.90	<b>Benefit:</b> 75% = \$54.70	
<b>Fee</b> 32156		O, SUBCUTANEOUS, excision of (Anaes.)	

T8. SUF	RGICAL OPERAT	TIONS 2. COLORECTAL	
	Fee: \$137.05	<b>Benefit:</b> 75% = \$102.80 85% = \$116.50	
		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.)	
Fee 32159	Fee: \$346.75	<b>Benefit:</b> 75% = \$260.10	
Fee		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: \$503.60	<b>Benefit:</b> 75% = \$377.70	
<b>D</b>	ANAL FISTUL	A, repair of, by mucosal flap advancement (Anaes.) (Assist.)	
Fee 32165	Fee: \$660.40	<b>Benefit:</b> 75% = \$495.30 85% = \$575.70	
	ANAL FISTUL	A - readjustment of Seton (Anaes.)	
Fee 32166	Fee: \$214.55	<b>Benefit:</b> 75% = \$160.95 85% = \$182.40	
	FISTULA WOU (Anaes.)	JND, review of, under general or regional anaesthetic, as an independent procedure	
Fee 32168	Fee: \$137.05	<b>Benefit:</b> 75% = \$102.80	
_		EXAMINATION, with or without biopsy, under general anaesthetic, not being a service a service to which another item in this Group applies (Anaes.)	
Fee 32171	Fee: \$92.35	<b>Benefit:</b> 75% = \$69.30	
	INTR-AANAL,	perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)	
Fee 32174	Fee: \$92.35	<b>Benefit:</b> 75% = \$69.30 85% = \$78.50	
	INTRA-ANAL,	RA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating re of a hospital (excluding aftercare) (Anaes.)	
Fee 32175	Fee: \$169.25	<b>Benefit:</b> 75% = \$126.95	
	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.)		
Fee 32177	Fee: \$181.30	<b>Benefit:</b> 75% = \$136.00	
	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.)		
Fee 32180	Fee: \$267.35	<b>Benefit:</b> 75% = \$200.55	
	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.)		
Fee 32183	Fee: \$584.40	<b>Benefit:</b> 75% = \$438.30	
22105		VAGE, total, intra operative (Anaes.) (Assist.)	
Fee 32186	Fee: \$584.40	<b>Benefit:</b> 75% = \$438.30	
		Benefit: 75% = \$438.30         CLE, devascularisation of (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERATIONS	2. COLORECTAL		
	ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.)			
Fee 32203	<b>Fee:</b> \$660.75 <b>Benefit:</b> 75% = \$495.60			
_	STIMULATOR AND ELECTRODES, insertion of, following previous g	raciloplasty (Anaes.) (Assist.)		
Fee 32206	<b>Fee:</b> \$596.95 <b>Benefit:</b> 75% = \$447.75			
	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator (Assist.)	and electrodes (Anaes.)		
Fee 32209	<b>Fee:</b> \$959.30 <b>Benefit:</b> 75% = \$719.50			
	GRACILIS NEOSPHINCTER PACEMAKER, replacement of (Anaes.)			
Fee 32210	<b>Fee:</b> \$265.80 <b>Benefit:</b> 75% = \$199.35 85% = \$225.95			
	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of rad performed in the operating theatre of a hospital, excluding aftercare (Ana			
Fee 32212	<b>Fee:</b> \$141.80 <b>Benefit:</b> 75% = \$106.35			
	Sacral nerve lead or leads, percutaneous placement using fluoroscopic gu intraoperative test stimulation, to manage faecal incontinence in a patient			
	a) has an anatomically intact but functionally deficient anal sphincter; and	1		
	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			
E	k) has had rectal or anal surgery within the previous 12 months (Anaes.)			
Fee 32213	<b>Fee:</b> \$687.75 <b>Benefit:</b> 75% = \$515.85			
	Neurostimulator or receiver, subcutaneous placement of, involving placement extension wire to a sacral nerve electrode using fluoroscopic guidance, to a patient who:			
-	a) has an anatomically intact but functionally deficient anal sphincter; and	1		
<b>Fee</b> 32214	b) has faecal incontinence that has been refractory to conservative non-su	rgical treatment for at least 12		

## 2. COLORECTAL

T8. SUF	RGICAL OPERATIONS 2. COLORECT
	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.) (Assist.)
	<b>Fee:</b> \$347.55 <b>Benefit:</b> 75% = \$260.70
	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who:
	a) is medically unfit for surgery; or
	b) is pregnant or planning pregnancy; or
	c) has irritable bowel syndrome; or
	d) has congenital anorectal malformations; or
	e) has active anal abscesses or fistulas; or
	f) has anorectal organic bowel disease, including cancer; or
	g) has functional effects of previous pelvic irradiation; or
	h) has congenital or acquired malformations of the sacrum; or
	i) has had rectal or anal surgery within the previous 12 months
	–each day
Fee 32215	Fee: \$130.45         Benefit: 75% = \$97.85         85% = \$110.90
	Sacral nerve lead or leads, percutaneous surgical repositioning of, using fluoroscopic guidance (or ope 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
Fee 32216	b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 1

## 2 COLORECTAL

T8. SUR	GICAL OPERATIONS	2. COLORECTAL
	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.)	
	<b>Fee:</b> \$617.60 <b>Benefit:</b> 75% = \$463.20	
	Neurostimulator or receiver, removal of, if the neurostimulator or receiver was insincontinence in a patient who:	serted to manage faecal
	a) has an anatomically intact but functionally deficient anal sphincter; and	
	b) has faecal incontinence that has been refractory to conservative non-surgical tra- months;	eatment for at least 12
	other than a patient who:	
	c) is medically unfit for surgery; or	
	d) is pregnant or planning pregnancy; or	
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months	
<b>Fee</b> 32217	(Anaes.)	

T8. SUR	GICAL OPERATIONS	2. COLORECTAL		
	<b>Fee:</b> \$162.65 <b>Benefit:</b> 75% = \$122.00			
	Sacral nerve lead or leads, removal of, if the lead was inserted to manage faeca who:	l incontinence in a patient		
	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 l 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			
Fee	(Anaes.)			
32218	<b>Fee:</b> \$162.65 <b>Benefit:</b> 75% = \$122.00			
	Insertion of an artificial bowel sphincter for severe faecal incontinence in the tr whom conservative and other less invasive forms of treatment are contraindica failed. Contraindicated in:			
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progradiseases or a scarred or fragile perineum; and	ressive degenerative		
	(b) patients who have had an adverse reaction or radiopaque solution; and			
Eco	(c) patients who enage in receptive anal intercourse (Anaes.) (Assist.)			
Fee 32220	Fee:         \$940.55         Benefit:         75% = \$705.45         85% = \$855.85			
	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 treatment are contraindicated or have failed. Contraindicated in:			
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progradiseases or a scarred or fragile perineum; and	ressive degenerative		
	(b) patients who have had an adverse reaction to radiopaque solution; and			
<b>Fee</b> 32221	(c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)			

T8. SUR	GICAL OPERATIONS	2. COLORECTAL	
	<b>Fee:</b> \$940.55 <b>Benefit:</b> 75% = \$705	.45 85% = \$855.85	
	Endoscopic examination of the colon to t	he caecum by colonoscopy, for a patient:	
	(a) following a positive faecal occult bloc	od test; or	
	(b) who has symptoms consistent with pa	thology of the colonic mucosa; or	
	(c) with anaemia or iron deficiency; or		
	(d) for whom diagnostic imaging has sho	wn an abnormality of the colon; or	
	(e) who is undergoing the first examination	on following surgery for colorectal cancer; or	
	(f) who is undergoing pre-operative evalu	ation; or	
	(g) for whom a repeat colonoscopy is req previous colonoscopy; or	uired due to inadequate bowel preparation for the patient's	
	(h) for the management of inflammatory	bowel disease	
	Applicable only once on a day under a signal	ngle episode of anaesthesia or other sedation (Anaes.)	
<b>Fee</b> 32222	(See para TN.8.152, TN.8.17, TN.8.2 of expla <b>Fee:</b> \$347.90 <b>Benefit:</b> 75% = \$260		
	Endoscopic examination of the colon to t	he caecum by colonoscopy, for a patient:	
	(a) who has had a colonoscopy that revea	led:	
	(i) 1 to 4 adenomas, each of which had no high grade dysplasia; or	was less than 10 mm in diameter, had no villous features and	
	(ii) 1 or 2 sessile serrated lesions, each of which was less than 10 mm in diameter, and v dysplasia; or		
	(b) with a moderate risk of colorectal can	cer due to family history; or	
	(c) with a history of colorectal cancer, where the reveal any adenomas or colorectal cancer	no has had an initial post-operative colonoscopy that did not	
	Applicable only once in any 5 year period	1.	
<b>Fee</b> 32223	(See para TN.8.152, TN.8.2, TN.8.17 of expla <b>Fee:</b> \$347.90 <b>Benefit:</b> 75% = \$260		
	Endoscopic examination of the colon to t of colorectal cancer due to:	he caecum by colonoscopy, for a patient with a moderate risk	
	(a) a history of adenomas, including an a	denoma that:	
	(i) was 10 mm or greater in diameter	er; or	
	(ii) had villous features; or		
	(iii) had high grade dysplasia; or		
<b>Fee</b> 32224	(b) having had a previous colonoscopy th	at revealed:	

T8. SURG	GICAL OPERATIONS 2. COLORECTAI
	(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.)
	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$347.90 <b>Benefit:</b> 75% = \$260.95 85% = \$295.75
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a high risk of colorectal cancer due to having had a previous colonoscopy that:
	(a) revealed 10 or more adenomas; or
	(b) included a piecemeal, or possibly incomplete, excision of a large, sessile polyp
	Applicable not more than 4 times in any 12 month period (Anaes.)
<b>Fee</b> 32225	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$347.90 <b>Benefit:</b> 75% = \$260.95 85% = \$295.75
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk of colorectal cancer due to:
	(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 had dysplasia; or
	(iii) 3 or more traditional serrated adenomas, of any size
	Applicable only once in any 12 month period (Anaes.)
<b>Fee</b> 32226	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$347.90 <b>Benefit:</b> 75% = \$260.95 85% = \$295.75
	Endoscopic examination of the colon to the caecum by colonoscopy:
<b>Fee</b> 32227	(a) for the treatment of bleeding, including one or more of the following:

T8. SUF	RGICAL OPERATIONS	2. COLORECTAL
	(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 sed	ation (Anaes.)
	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) <b>Fee:</b> \$488.20 <b>Benefit:</b> 75% = \$366.15 85% = \$415.00	
	Endoscopic examination of the colon to the caecum by colonoscopy, other that a 32222, 32223, 32224, 32225, or 32226 applies. Applicable only once (Anaes.)	service to which item
Fee 32228	(See para TN.8.17, TN.8.2, TN.8.152 of explanatory notes to this Category) <b>Fee:</b> \$347.90 <b>Benefit:</b> 75% = \$260.95 85% = \$295.75	
	Removal of one or more polyps during colonoscopy, in association with a service 32223, 32224, 32225, 32226, or 32228 applies	e to which item 32222,
	(Anaes.)	
Fee 32229	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) <b>Fee:</b> \$280.60 <b>Benefit:</b> 75% = \$210.45 85% = \$238.55	
T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	Group T8. Surgical Operations	
	Subgroup 3. Vascular	
	VARICOSE VEINS	
	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, m sclerosant using continuous compression techniques, including associated consul not being a service associated with any other varicose vein operation on the same care) - to a maximum of 6 treatments in a 12 month period (Anaes.)	tation - 1 or both legs -
<b>Fee</b> 32500	(See para TN.8.4, TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$114.20 <b>Benefit:</b> 75% = \$85.65 85% = \$97.10 <b>Extended Medicare Safety Net Cap:</b> \$125.65	
	VARICOSE VEINS, multiple excision of tributaries, with or without division of veins - 1 leg - not being a service associated with a service to which item 32507, 32517 applies on the same leg (Anaes.)	
<b>Fee</b> 32504	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$278.55 <b>Benefit:</b> 75% = \$208.95 85% = \$236.80 <b>Extended Medicare Safety Net Cap:</b> \$222.85	
	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompeten leg - not being a service associated with a service to which item 32508, 32511, 32 on the same leg (Anaes.) (Assist.)	
<b>Fee</b> 32507	(See para TN.8.32 of explanatory notes to this Category)         Fee: \$555.25       Benefit: 75% = \$416.45       85% = \$472.00         Extended Medicare Safety Net Cap: \$444.20	

T8. SUF	GICAL OPERATIONS	3. VASCULAR
	VARICOSE VEINS, complete dissection at the sapheno-femoral OR sapheno-pop with or without either ligation or stripping, or both, of the long or short saphenous time on the same leg, including excision or injection of either tributaries or incomp veins, or both (Anaes.) (Assist.)	veins, for the first
Fee 32508	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$555.25 <b>Benefit:</b> 75% = \$416.45	
	VARICOSE VEINS, complete dissection at the sapheno-femoral AND sapheno-poleg - with or without either ligation or stripping, or both, of the long or short sapher first time on the same leg, including excision or injection of either tributaries or increase, or both (Anaes.) (Assist.)	nous veins, for the
<b>Fee</b> 32511	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$825.45 <b>Benefit:</b> 75% = \$619.10	
	VARICOSE VEINS, ligation of the long or short saphenous vein on the same leg, stripping, by re-operation for recurrent veins in the same territory - 1 leg - includin of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)	
<b>Fee</b> 32514	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$964.35 <b>Benefit:</b> 75% = \$723.30	
	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg stripping, by re-operation for recurrent veins in either territory - 1 leg - including e either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)	
<b>Fee</b> 32517	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$1,241.80 <b>Benefit:</b> 75% = \$931.35	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent gu (short) saphenous vein of one leg (and major tributaries of saphenous veins as nece probe introduced by an endovenous catheter, if it is documented by duplex ultrasou small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 second	essary), using a laser and that the great or
	(a) including all preparation and immediate clinical aftercare (including excision or tributaries or incompetent perforating veins, or both); and	r injection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacryl	ate embolisation; and
	(c) not provided on the same occasion as a service described in any of items 32500 (Anaes.)	, 32504 and 32507
<b>Fee</b> 32520	(See para TN.8.33 of explanatory notes to this Category) <b>Fee:</b> \$555.25 <b>Benefit:</b> 75% = \$416.45 85% = \$472.00 <b>Extended Medicare Safety Net Cap:</b> \$83.30	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent gr (short) saphenous vein of one leg (and major tributaries of saphenous veins as nece probe introduced by an endovenous catheter, if it is documented by duplex ultrasou small saphenous veins demonstrate reflux of 0.5 seconds or longer:	essary), using a laser
	(a) including all preparation and immediate clinical aftercare (including excision or tributaries or incompetent perforating veins, or both); and	r injection of either
<b>Fee</b> 32522	(b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacryl not provided on the same occasion as a service described in any of items 32500, 32 (Anaes.)	

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	(See para TN.8.33 of explanatory notes to this Category)         Fee: \$825.45       Benefit: 75% = \$619.10       85% = \$740.75         Extended Medicare Safety Net Cap: \$82.55	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent (short) saphenous vein of one leg (and major tributaries of saphenous veins as ne radiofrequency catheter introduced by an endovenous catheter, if it is documented that the great or small saphenous vein (whichever is to be treated) demonstrates longer:	ecessary), using a ed by duplex ultrasound
	(a) including all preparation and immediate clinical aftercare (including excision tributaries or incompetent perforating veins, or both); and	or injection 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 325 (Anaes.)	00, 32504 and 32507
<b>Fee</b> 32523	(See para TN.8.33 of explanatory notes to this Category) <b>Fee:</b> \$555.25 <b>Benefit:</b> 75% = \$416.45 85% = \$472.00 <b>Extended Medicare Safety Net Cap:</b> \$83.30	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent (short) saphenous vein of one leg (and major tributaries of saphenous veins as ne radiofrequency catheter introduced by an endovenous catheter, if it is documented that the great and small saphenous veins demonstrate reflux of 0.5 seconds or low	ecessary), using a ed by duplex ultrasound
	(a) including all preparation and immediate clinical aftercare (including excision tributaries or incompetent perforating veins, or both); and	or injection 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 325 (Anaes.)	00, 32504 and 32507
<b>Fee</b> 32526	(See para TN.8.33 of explanatory notes to this Category)         Fee: \$825.45       Benefit: 75% = \$619.10       85% = \$740.75         Extended Medicare Safety Net Cap: \$82.55	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent (short) saphenous vein of one leg (and major tributaries of saphenous veins as ne cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great o (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer:	ecessary), using
	(a) including all preparation and immediate clinical aftercare (including excision tributaries or incompetent perforating veins, or both); and	or injection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or endoven	ous laser therapy; and
	(c) not provided on the same occasion as a service described in any of items 325	00, 32504 and 32507
	(Anaes.)	
<b>Fee</b> 32528	(See para TN.8.33 of explanatory notes to this Category)         Fee: \$555.25       Benefit: 75% = \$416.45       85% = \$472.00         Extended Medicare Safety Net Cap: \$83.30	
Fee	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent	t great (long) and small

T8. SUF		ONS	3. VASCULAR
32529	cyanoacrylate adh	vein of one leg (and major tributaries of saphenous vein nesive, if it is documented by duplex ultrasound that the e reflux of 0.5 seconds or longer:	
		reparation and immediate clinical aftercare (including ex mpetent perforating veins, or both); and	acision or injection of either
	(b) not including	radiofrequency diathermy, radiofrequency ablation or en	dovenous laser therapy; and
	(c) not provided of	on the same occasion as a service described in any of iten	ns 32500, 32504 and 32507
	(Anaes.)		
	Fee: \$825.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$619.10 85% = \$740.75 <b>are Safety Net Cap:</b> \$82.55	
	E	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTER	RIAL DISEASE
Eac	ARTERY OF NE	CK, bypass using vein or synthetic material (Anaes.) (A	ssist.)
Fee 32700	Fee: \$1,494.55	<b>Benefit:</b> 75% = \$1120.95	
		ROTID ARTERY, transection and reanastomosis of, or re- with or without endarterectomy (Anaes.) (Assist.)	esection of small length and
Fee 32703	Fee: \$1,236.35	<b>Benefit:</b> 75% = \$927.30	
	AORTIC BYPAS	S for occlusive disease using a straight non-bifurcated g	raft (Anaes.) (Assist.)
Fee 32708	Fee: \$1,478.95	<b>Benefit:</b> 75% = \$1109.25	
	AORTIC BYPAS arteries (Anaes.) (	S for occlusive disease using a bifurcated graft with 1 or (Assist.)	both anastomoses to the iliac
Fee 32710	Fee: \$1,643.25	<b>Benefit:</b> 75% = \$1232.45	
		S for occlusive disease using a bifurcated graft with 1 or or profunda femoris arteries (Anaes.) (Assist.)	both anastomoses to the
Fee 32711	Fee: \$1,807.65	<b>Benefit:</b> 75% = \$1355.75	
	ILIO-FEMORAL	BYPASS GRAFTING (Anaes.) (Assist.)	
Fee 32712	Fee: \$1,306.70	<b>Benefit:</b> 75% = \$980.05	
	AXILLARY or S ARTERIES (Ana	UBCLAVIAN TO FEMORAL BYPASS GRAFTING to es.) (Assist.)	0 1 or both FEMORAL
Fee 32715	Fee: \$1,306.70	<b>Benefit:</b> 75% = \$980.05	
	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.)		
Fee 32718	Fee: \$1,236.35	<b>Benefit:</b> 75% = \$927.30	
		Y, bypass grafting to (Anaes.) (Assist.)	
<b>Fee</b> 32721	Fee: \$1,963.80	<b>Benefit:</b> 75% = \$1472.85	
_	RENAL ARTERI	ES (both), bypass grafting to (Anaes.) (Assist.)	
Fee 32724	Fee: \$2,229.95	<b>Benefit:</b> 75% = \$1672.50	

T8. SUF	GICAL OPERATIO	NS	3. VASCULAR
	MESENTERIC VI	ESSEL (single), bypass grafting to (Anaes.) (Assist.)	
Fee 32730	Fee: \$1,690.15	<b>Benefit:</b> 75% = \$1267.65	
		ESSELS (multiple), bypass grafting to (Anaes.) (Assis	st.)
Fee 32733	<b>Fee:</b> \$1,963.80	<b>Benefit:</b> 75% = \$1472.85	
52755		NTERIC ARTERY, operation on, when performed in	a conjunction with another intra-
		r operation (Anaes.) (Assist.)	reorganetion with another mata
Fee 32736	Fee: \$430.30	<b>Benefit:</b> 75% = \$322.75	
	FEMORAL ARTE	RY BYPASS GRAFTING using vein, including harv henous vein) with above knee anastomosis (Anaes.) (	•
Fee 32739	Fee: \$1,345.80	<b>Benefit:</b> 75% = \$1009.35	
Fee		RY BYPASS GRAFTING using vein, including harv henous vein) with distal anastomosis to below knee p	
32742	Fee: \$1,541.55	<b>Benefit:</b> 75% = \$1156.20	
_		RY BYPASS GRAFTING using vein, including harv henous vein) with distal anastomosis to tibio peronea ssist.)	
Fee 32745	Fee: \$1,760.50	<b>Benefit:</b> 75% = \$1320.40	
Fac	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (whe ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Anatomic States) and the same set of the angle of the angle of the same set of the same		
Fee 32748	Fee: \$1,909.15	<b>Benefit:</b> 75% = \$1431.90	
_	FEMORAL ARTE below the knee (A	RY BYPASS GRAFTING using synthetic graft, with naes.) (Assist.)	1 lower anastomosis above or
Fee 32751	Fee: \$1,236.35	<b>Benefit:</b> 75% = \$927.30	
		RY BYPASS GRAFTING, using a composite graft ( above or below the knee, including use of a cuff or sl es.) (Assist.)	
Fee 32754	Fee: \$1,541.55	<b>Benefit:</b> 75% = \$1156.20	
	an additional anast	RY SEQUENTIAL BYPASS GRAFTING, (using a omosis is made to separately revascularise more than ond a femoral bypass (Anaes.) (Assist.)	
Fee 32757	Fee: \$430.30	<b>Benefit:</b> 75% = \$322.75	
_		ING OF, FROM LEG OR ARM for bypass or replace is the subject of the bypass or graft - each vein (Anae	
Fee 32760	Fee: \$422.50	<b>Benefit:</b> 75% = \$316.90	
		ASS GRAFTING, using vein or synthetic material, no s Sub-group applies (Anaes.) (Assist.)	t being a service to which
Fee 32763	Fee: \$1,236.35	<b>Benefit:</b> 75% = \$927.30	
<b>Fee</b> 32766	ARTERIAL OR V	ENOUS ANASTOMOSIS, not being a service to wh	ich another item in this Sub-

GICAL OPERATIO	DNS	3. VASCULAR
group applies, as a	n independent procedure (Anaes.) (Assist.)	
Fee: \$821.70	<b>Benefit:</b> 75% = \$616.30	
group applies, whe	en performed in combination with another vascular operation (i	
<b>Fee:</b> \$284 75	<b>Benefit:</b> 75% – \$213.60	
100. \$204.75		
	ING to replace a popliteal aneurysm using vein, including harv	
Fee: \$1,514.30	<b>Benefit:</b> 75% = \$1135.75	
BYPASS GRAFT	ING to replace a popliteal aneurysm using a synthetic graft (Ar	naes.) (Assist.)
Fee: \$1,214.35	<b>Benefit:</b> 75% = \$910.80	
ANEURYSM IN (Anaes.) (Assist.)	THE EXTREMITIES, ligation, suture closure or excision of, w	ithout bypass grafting
Fee: \$876.10	<b>Benefit:</b> 75% = \$657.10 85% = \$791.40	
ANEURYSM IN ' (Assist.)	THE NECK, ligation, suture closure or excision of, without by	pass grafting (Anaes.)
Fee: \$1,114.45	<b>Benefit:</b> 75% = \$835.85	
		cision of, without
Fee: \$1,360.45	<b>Benefit:</b> 75% = \$1020.35	
		l, replacement by graft
Fee: \$1,494.55	<b>Benefit:</b> 75% = \$1120.95 85% = \$1409.85	
	URYSM, replacement by graft (Anaes.) (Assist.)	
Fee: \$2,096.95	<b>Benefit:</b> 75% = \$1572.75	
		plantation of arteries
Fee: \$2,535.25	<b>Benefit:</b> 75% = \$1901.45 85% = \$2450.55	
SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.)		
Fee: \$2,198.70	<b>Benefit:</b> 75% = \$1649.05	
INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a serve		aft, not being a service
associated with a service to which item 33116 applies (Anaes.) (Assist.)		
Fee: \$1,478.95	<b>Benefit:</b> 75% = \$1109.25	
	· · ·	aft using endovascular
Fee: \$1,455.70	<b>Benefit:</b> 75% = \$1091.80 85% = \$1371.00	
	group applies, as aFee: \$821.70ARTERIAL OR V group applies, whe anastomosis) (AnaFee: \$284.75BYPASS GRAFT the ipsilateral longFee: \$1,514.30BYPASS GRAFT the ipsilateral longFee: \$1,514.30BYPASS GRAFT the ipsilateral longFee: \$1,514.30BYPASS GRAFT the ipsilateral longFee: \$1,114.35ANEURYSM IN T 	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which anothe group applies, when performed in combination with another vascular operation (i anastomosis) (Anaes.) (Assist.)         Fee: \$284.75       Benefit: 75% = \$213.60         BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harv the ipsilateral long saphenous vein) (Anaes.) (Assist.)         Fee: \$1.514.30       Benefit: 75% = \$1135.75         BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Arr Fee: \$1.214.35       Benefit: 75% = \$910.80         ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, w (Anaes.) (Assist.)       Fee: \$876.10         Fee: \$876.10       Benefit: 75% = \$657.10       85% = \$791.40         ANEURYSM IN THE NECK, ligation, suture closure or excision of, without by (Assist.)       Fee: \$1,114.45       Benefit: 75% = \$835.85         INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or exbypass grafting (Anaes.) (Assist.)       Fee: \$1,360.45       Benefit: 75% = \$1020.35         ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH of vein or synthetic material (Anaes.) (Assist.)       Fee: \$1,494.55       Benefit: 75% = \$1120.95       85% = \$1409.85         THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.)       Fee: \$2,096.95       Benefit: 75% = \$1901.45       85% = \$2450.55         SUPRARENAL ABDOMINAL ANEURYSM, replacement by graft including re-im (Anaes.) (Assist.)       Fee: \$2,198.70       Benefit: 75% = \$1649.05       INFRARENAL ABDOMINAL AORTIC ANEURYSM, repla

T8. SUF		ONS	3. VASCULAR
Fac	arteries (with or w	BDOMINAL AORTIC ANEURYSM, replacent without excision of common iliac aneurysms) not tem 33119 applies (Anaes.) (Assist.)	
<b>Fee</b> 33118	Fee: \$1,643.25	<b>Benefit:</b> 75% = \$1232.45	
		BDOMINAL AORTIC ANEURYSM, replacen gendovascular repair procedure, excluding assoc	
Fee 33119	Fee: \$1,617.55	<b>Benefit:</b> 75% = \$1213.20 85% = \$1532.85	
Fee		BDOMINAL AORTIC ANEURYSM, replacent with or without excision or bypass of common illing	
33121	Fee: \$1,807.65	<b>Benefit:</b> 75% = \$1355.75	
Fac	ANEURYSM OF (Anaes.) (Assist.)	ILIAC ARTERY (common, external or internal	), replacement by graft - unilateral
Fee 33124	Fee: \$1,259.85	<b>Benefit:</b> 75% = \$944.90	
F	ANEURYSMS O (Anaes.) (Assist.)	F ILIAC ARTERIES (common, external or inter	rnal), replacement by graft - bilateral
Fee 33127	Fee: \$1,651.10	<b>Benefit:</b> 75% = \$1238.35 85% = \$1566.40	
	ANEURYSM OF graft (Anaes.) (As	VISCERAL ARTERY, excision and repair by c sist.)	lirect anastomosis or replacement by
Fee 33130	Fee: \$1,439.75	<b>Benefit:</b> 75% = \$1079.85	
	ANEURYSM OF continuity (Anaes	VISCERAL ARTERY, dissection and ligation ( .) (Assist.)	of arteries without restoration of
Fee 33133	Fee: \$1,079.70	<b>Benefit:</b> 75% = \$809.80	
-	FALSE ANEURY (Assist.)	SM, repair of, at aortic anastomosis following p	previous aortic surgery (Anaes.)
Fee 33136	Fee: \$2,722.80	<b>Benefit:</b> 75% = \$2042.10	
Fee		SM, repair of, in iliac artery and restoration of a	arterial continuity (Anaes.) (Assist.)
33139	<b>Fee:</b> \$1,651.10	<b>Benefit:</b> 75% = \$1238.35	
<b>Fee</b> 33142	FALSE ANEUR Y Fee: \$1,541.55	SM, repair of, in femoral artery and restoration <b>Benefit:</b> 75% = \$1156.20 85% = \$1456.85	of arterial continuity (Anaes.) (Assist.)
	RUPTURED THO	DRACIC AORTIC ANEURYSM, replacement b	by graft (Anaes.) (Assist.)
Fee 33145	Fee: \$2,652.50	<b>Benefit:</b> 75% = \$1989.40	
<b>F</b> .	RUPTURED THO (Assist.)	DRACO-ABDOMINAL AORTIC ANEURYSM	I, replacement by graft (Anaes.)
<b>Fee</b> 33148	Fee: \$3,294.10	<b>Benefit:</b> 75% = \$2470.60	
	RUPTURED SUF (Assist.)	PRARENAL ABDOMINAL AORTIC ANEURY	YSM, replacement by graft (Anaes.)
Fee 33151	Fee: \$3,129.80	<b>Benefit:</b> 75% = \$2347.35	

T8. SUR	GICAL OPERATION	ONS	3. VASCULAR
	RUPTURED INF (Anaes.) (Assist.)	RARENAL ABDOMINAL AORTIC ANEURYSM, repl	acement by tube graft
Fee 33154	Fee: \$2,316.05	<b>Benefit:</b> 75% = \$1737.05	
		RARENAL ABDOMINAL AORTIC ANEURYSM, repl ith or without excision or bypass of common iliac aneury	
Fee	<b>Fee:</b> \$2,582.05	<b>Benefit:</b> 75% = \$1936.55	
33157		RARENAL ABDOMINAL AORTIC ANEURYSM, repl	accomant by hituration graft
		al arteries (Anaes.) (Assist.)	accilient by birurcation grant
Fee 33160	Fee: \$2,582.05	<b>Benefit:</b> 75% = \$1936.55	
	RUPTURED ILIA	AC ARTERY ANEURYSM, replacement by graft (Anaes	s.) (Assist.)
Fee 33163	Fee: \$2,191.05	<b>Benefit:</b> 75% = \$1643.30	
		EURYSM OF VISCERAL ARTERY, replacement by and	astomosis or graft (Anaes.)
Fee 33166	Fee: \$2,191.05	<b>Benefit:</b> 75% = \$1643.30 85% = \$2106.35	
55100		EURYSM OF VISCERAL ARTERY, simple ligation of (	Anaes.) (Assist.)
Fee 33169	Fee: \$1,705.80	<b>Benefit:</b> 75% = \$1279.35	()
	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item this Sub-group applies (Anaes.) (Assist.)		
Fee		• · · · · · ·	
33172	IT2         Fee: \$1,330.15         Benefit: 75% = \$997.65           RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision		re or excision of without
	bypass grafting (A		ine of excision of, without
Fee 33175	Fee: \$1,225.85	<b>Benefit:</b> 75% = \$919.40	
_	RUPTURED ANI grafting (Anaes.)	EURYSM IN THE NECK, ligation, suture closure or exc (Assist.)	ision of, without bypass
Fee 33178	Fee: \$1,558.90	<b>Benefit:</b> 75% = \$1169.20	
		RA-ABDOMINAL OR PELVIC ANEURYSM, ligation, afting (Anaes.) (Assist.)	suture closure or excision of,
Fee 33181	Fee: \$1,905.90	<b>Benefit:</b> 75% = \$1429.45	
55101		ENDARTERECTOMY AND ARTERIAL PATCH	4
		TERIES OF NECK, endarterectomy of, including closure f 1 or more arteries is undertaken through 1 arteriotomy ir	e by suture (where
Fee 33500	<b>Fee:</b> \$1,181.40	<b>Benefit:</b> 75% = \$886.05	
	INNOMINATE C (Assist.)	OR SUBCLAVIAN ARTERY, endarterectomy of, includi	ng closure by suture (Anaes.)
Fee 33506	Fee: \$1,322.40	<b>Benefit:</b> 75% = \$991.80	
-	AORTIC ENDAR	RTERECTOMY, including closure by suture, not being a on the aorta (Anaes.) (Assist.)	service associated with
Fee 33509	<b>Fee:</b> \$1,478.95	Benefit: 75% = \$1109.25	

T8. SUF	RGICAL OPERATI	ONS	3. VASCULAR
F		ENDARTERECTOMY (1 or both iliac arteries), incl d with a service to which item 33515 applies (Anaes.	
Fee 33512	Fee: \$1,643.25	<b>Benefit:</b> 75% = \$1232.45	
	FEMORAL END	RAL ENDARTERECTOMY (1 or both femoral arter DARTERECTOMY, including closure by suture, not item 33512 applies (Anaes.) (Assist.)	
Fee 33515	Fee: \$1,807.65	<b>Benefit:</b> 75% = \$1355.75	
Ess		ERECTOMY, including closure by suture, not being iliac artery (Anaes.) (Assist.)	g a service associated with another
Fee 33518	Fee: \$1,322.40	<b>Benefit:</b> 75% = \$991.80 85% = \$1237.70	
Fee	ILIO-FEMORAL	ENDARTERECTOMY (1 side), including closure	by suture (Anaes.) (Assist.)
33521	Fee: \$1,431.80	<b>Benefit:</b> 75% = \$1073.85	
_	RENAL ARTER	Y, endarterectomy of (Anaes.) (Assist.)	
Fee 33524	Fee: \$1,690.15	<b>Benefit:</b> 75% = \$1267.65	
	RENAL ARTER	IES (both), endarterectomy of (Anaes.) (Assist.)	
Fee 33527	Fee: \$1,963.80	<b>Benefit:</b> 75% = \$1472.85	
	COELIAC OR S	UPERIOR MESENTERIC ARTERY, endarterectom	y of (Anaes.) (Assist.)
Fee 33530	Fee: \$1,690.15	<b>Benefit:</b> 75% = \$1267.65	
-	COELIAC AND	SUPERIOR MESENTERIC ARTERY, endarterector	omy of (Anaes.) (Assist.)
Fee 33533	Fee: \$1,963.80	<b>Benefit:</b> 75% = \$1472.85	
		ENTERIC ARTERY, endarterectomy of, not being a item in this Sub-group applies (Anaes.) (Assist.)	a service associated with a service
Fee 33536	Fee: \$1,400.65	<b>Benefit:</b> 75% = \$1050.50	
		TREMITIES, endarterectomy of, including closure	by suture (Anaes.) (Assist.)
Fee 33539	Fee: \$1,009.35	<b>Benefit:</b> 75% = \$757.05	
		EP FEMORAL ENDARTERECTOMY where the en	ndarterectomy is at least 7cms long
Fee 33542	<b>Fee:</b> \$1,439.75	<b>Benefit:</b> 75% = \$1079.85	
		OR BYPASS GRAFT, patch grafting to by vein or s g (Anaes.) (Assist.)	synthetic material where patch is
<b>Fee</b> 33545	(See para TN.8.36 <b>Fee:</b> \$284.75	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$213.60	
_		OR BYPASS GRAFT, patch grafting to by vein or s ter (Anaes.) (Assist.)	synthetic material where patch is
<b>Fee</b> 33548	(See para TN.8.36 <b>Fee:</b> \$579.15	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$434.40	
<b>Fee</b> 33551	VEIN, harvesting	g of from leg or arm for patch when not performed th	rough same incision as operation

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	(Anaes.) (Assist.)	
	(See para TN.8.36 of explanatory notes to this Category) <b>Fee:</b> \$284.75 <b>Benefit:</b> 75% = \$213.60	
	ENDARTERECTOMY, in conjunction with an arterial bypass operation	to prepare the site for
Fee	anastomosis - each site (Anaes.) (Assist.)	
33554	<b>Fee:</b> \$283.45 <b>Benefit:</b> 75% = \$212.60	
	EMBOLECTOMY, THROMBECTOMY AND VASCUL	AR TRAUMA
	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.)	
Fee 33800	<b>Fee:</b> \$1,228.45 <b>Benefit:</b> 75% = \$921.35 85% = \$1143.75	
	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of trunk (Anaes.) (Assist.)	an artery or bypass graft of
Fee 33803	<b>Fee:</b> \$1,173.75 <b>Benefit:</b> 75% = \$880.35	
Ess	Embolectomy or thrombectomy (including the infusion of thrombolytic or or bypass graft of extremities, or embolectomy of abdominal artery via the claimed once per extremity, regardless of the number of incisions required graft (Anaes.) (Assist.)	he femoral artery, item to be
Fee 33806	<b>Fee:</b> \$845.10 <b>Benefit:</b> 75% = \$633.85 85% = \$760.40	
	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by c	atheter via the femoral vein
-	(Anaes.) (Assist.)	
Fee 33810	<b>Fee:</b> \$616.50 <b>Benefit:</b> 75% = \$462.40 85% = \$531.80	
	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus	or tumour (Anaes.) (Assist.)
Fee		
33811	Fee:         \$1,835.25         Benefit:         75% = \$1376.45           TUDOMDUS         summary loss of	$(\mathbf{A}_{\text{reside}})$
Fee	THROMBUS, removal of, from femoral or other similar large vein (Ana	es.) (Assisi.)
33812	Fee: \$970.20         Benefit: 75% = \$727.65         85% = \$885.50	
	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with	th restoration of continuity, by
Fee	lateral suture (Anaes.) (Assist.)	
33815	<b>Fee:</b> \$892.00 <b>Benefit:</b> 75% = \$669.00	
<b>F</b>	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with direct anastomosis (Anaes.) (Assist.)	th restoration of continuity, by
Fee 33818	<b>Fee:</b> \$1,040.70 <b>Benefit:</b> 75% = \$780.55	
	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, wit interposition graft of synthetic material or vein (Anaes.) (Assist.)	th restoration of continuity, by
Fee 33821	<b>Fee:</b> \$1,189.30 <b>Benefit:</b> 75% = \$892.00	
	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restor suture (Anaes.) (Assist.)	ration of continuity, by lateral
<b>Fee</b> 33824	<b>Fee:</b> \$1,134.50 <b>Benefit:</b> 75% = \$850.90	
<b>Fee</b> 33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restor anastomosis (Anaes.) (Assist.)	ration of continuity, by direct

	DNS	3. VASCULAR
Fee: \$1,330.15	<b>Benefit:</b> 75% = \$997.65	
		n of continuity, by
Fee: \$1,525.70	<b>Benefit:</b> 75% = \$1144.30	
		oration of continuity by
Fee: \$1,385.10	<b>Benefit:</b> 75% = \$1038.85	
	-	oration of continuity by
Fee: \$1,651.10	<b>Benefit:</b> 75% = \$1238.35	
		oration of continuity by
Fee: \$1,932.65	<b>Benefit:</b> 75% = \$1449.50	
ARTERY OF NEG (Anaes.) (Assist.)	CK, re-operation for bleeding or thrombosis after carotid or	vertebral artery surgery
Fee: \$954.60	<b>Benefit:</b> 75% = \$715.95	
		ntra-abdominal vascular
Fee: \$665.15	<b>Benefit:</b> 75% = \$498.90	
		scular procedure, where no
Fee: \$665.15	<b>Benefit:</b> 75% = \$498.90	
LIGA	TION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION	NOF VESSELS
		a service associated with
Fee: \$735.60	<b>Benefit:</b> 75% = \$551.70	
exploration of imm iliac, femoral or po 32520, 32522, 325	nediate branches or tributaries, or ligation or exploration of opliteal arteries or veins, if the service is not associated wit 523, 32526, 32528 or 32529 - for a maximum of 2 services	f the subclavian, axillary, h item 32508, 32511,
Fee: \$430.30	<b>Benefit:</b> 75% = \$322.75	
ARTERY OR VE	being a service associated with any other vascular procedu	
Fee: \$303.50 Extended Medica	<b>Benefit:</b> 75% = \$227.65 85% = \$258.00 are Safety Net Cap: \$242.80	
	Fee: \$1,330.15MAJOR ARTERY interposition graftFee: \$1,525.70MAJOR ARTERY lateral suture (Ana Fee: \$1,385.10MAJOR ARTERY direct anastomosisFee: \$1,651.10MAJOR ARTERY direct anastomosisFee: \$1,651.10MAJOR ARTERY means of interposiFee: \$1,932.65ARTERY OF NEG (Anaes.) (Assist.)Fee: \$954.60LAPAROTOMY i procedure, where i Fee: \$665.15EXTREMITY, re- other procedure is Fee: \$665.15Fee: \$665.15EXTREMITY, re- other procedure is Fee: \$735.60Great artery (aorta exploration of imr iliac, femoral or p 32520, 32522, 325 patient on the sam Fee: \$430.30ARTERY OR VE exploration of, not which items 32508Fee: \$303.50Extended Medica	<ul> <li>MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration interposition graft of synthetic material or vein (Anaes.) (Assist.)</li> <li>Fee: \$1,525.70 Benefit: 75% = \$1144.30</li> <li>MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with rest lateral suture (Anaes.) (Assist.)</li> <li>Fee: \$1,385.10 Benefit: 75% = \$1038.85</li> <li>MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with rest direct anastomosis (Anaes.) (Assist.)</li> <li>Fee: \$1,651.10 Benefit: 75% = \$1238.35</li> <li>MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with rest direct anastomosis (Anaes.) (Assist.)</li> <li>Fee: \$1,651.10 Benefit: 75% = \$1249.50</li> <li>MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with rest means of interposition graft (Anaes.) (Assist.)</li> <li>Fee: \$1,932.65 Benefit: 75% = \$1449.50</li> <li>ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or (Anaes.) (Assist.)</li> <li>Fee: \$954.60 Benefit: 75% = \$715.95</li> <li>LAPAROTOMY for control of post operative bleeding or thrombosis after in procedure, where no other procedure is performed (Anaes.) (Assist.)</li> <li>Fee: \$665.15 Benefit: 75% = \$498.90</li> <li>EXTREMITY, re-operation on, for control of bleeding or thrombosis after variation of the procedure is performed (Anaes.) (Assist.)</li> <li>Fee: \$665.15 Benefit: 75% = \$498.90</li> <li>LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION</li> <li>MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a any other vascular procedure (Anaes.) (Assist.)</li> <li>Fee: \$735.60 Benefit: 75% = \$551.70</li> <li>Great artery (aorta or pulmonary artery) or great vein (superior or inferior vei exploration of immediate branches or tributaries, or ligation or exploration of iliac, femoral or popliteal arteries or veins, if the service is not associated wit 32520, 32522, 32523, 32526, 32528 or 32529 - for a maximum of 2 services patient on the same occasion (H) (Anaes.) (Assist</li></ul>

T8. SUF	RGICAL OPERATI	ONS	3. VASCULAR
	ARTERIO-VENO	DUS FISTULA OF AN EXTREMITY, diss	ection and ligation (Anaes.) (Assist.)
Fee 34112	Fee: \$892.00	<b>Benefit:</b> 75% = \$669.00	
	ARTERIO-VEN	DUS FISTULA OF THE NECK, dissection	and ligation (Anaes.) (Assist.)
Fee 34115	Fee: \$1,009.35	<b>Benefit:</b> 75% = \$757.05	
54115		DUS FISTULA OF THE ABDOMEN, disse	ection and ligation (Anaes) (Assist)
Fee			-
34118	<b>Fee:</b> \$1,439.75	<b>Benefit:</b> 75% = \$1079.85 85% = \$1355.0	
Fee	continuity (Anaes	DUS FISTULA OF AN EXTREMITY, diss 5.) (Assist.)	ection and repair of, with restoration of
34121	Fee: \$1,150.15	<b>Benefit:</b> 75% = \$862.65	
Fee	ARTERIO-VENO (Anaes.) (Assist.)		and repair of, with restoration of continuity
34124	Fee: \$1,259.85	<b>Benefit:</b> 75% = \$944.90	
	ARTERIO-VENC continuity (Anaes	DUS FISTULA OF THE ABDOMEN, disse s.) (Assist.)	ection and repair of, with restoration of
<b>Fee</b> 34127	Fee: \$1,651.10	<b>Benefit:</b> 75% = \$1238.35	
	SURGICALLY ( (Assist.)	CREATED ARTERIO-VENOUS FISTULA	OF AN EXTREMITY, closure of (Anaes.)
<b>Fee</b> 34130	Fee: \$516.40	<b>Benefit:</b> 75% = \$387.30 85% = \$438.95	
Fee	SCALENOTOM	Y (Anaes.) (Assist.)	
34133	Fee: \$579.15	<b>Benefit:</b> 75% = \$434.40	
	FIRST RIB, resea	ction of portion of (Anaes.) (Assist.)	
Fee 34136	Fee: \$931.00	<b>Benefit:</b> 75% = \$698.25	
			of thoracic outlet compression, not being a es.) (Assist.)
Fee 34139	Fee: \$931.00	<b>Benefit:</b> 75% = \$698.25	
		ERY, decompression of, for coeliac artery co	ompression syndrome, as an independent
<b>Fee</b> 34142	<b>Fee:</b> \$1,150.15	<b>Benefit:</b> 75% = \$862.65	
		TERY, exploration of, for popliteal entrapm (Anaes.) (Assist.)	nent, with or without division of fibrous
<b>Fee</b> 34145	Fee: \$837.20	<b>Benefit:</b> 75% = \$627.90	
		OCIATED TUMOUR, resection of, with or vide arterias, when tumour is 4cm or loss in m	1
Fee	or common carot	d arteries, when tumour is 4cm or less in ma	aximum utameter (Anaes.) (ASSIST.)
34148	Fee: \$1,494.55	<b>Benefit:</b> 75% = \$1120.95	
<b>.</b>		OCIATED TUMOUR, resection of, with or vid arteries, when tumour is greater than 4cm	
Fee	Fee: \$2,042.15	<b>Benefit:</b> 75% = \$1531.65	

T8. SUF		DNS	3. VASCULAR
		AROTID ASSOCIATED TUMOUR, resection of, with or without rtion of internal or common carotid arteries (Anaes.) (Assist.)	repair or
Fee 34154	Fee: \$2,433.50	<b>Benefit:</b> 75% = \$1825.15 85% = \$2348.80	
	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.)		
<b>Fee</b> 34157	Fee: \$1,236.35	<b>Benefit:</b> 75% = \$927.30	
Ess	AORTO-DUODE (Assist.)	NAL FISTULA, repair of, by suture of aorta and repair of duoden	um (Anaes.)
Fee 34160	Fee: \$2,316.05	<b>Benefit:</b> 75% = \$1737.05	
	AORTO-DUODE (Anaes.) (Assist.)	NAL FISTULA, repair of, by insertion of aortic graft and repair o	f duodenum
Fee 34163	Fee: \$2,973.30	<b>Benefit:</b> 75% = \$2230.00	
	AORTO-DUODE	NAL FISTULA, repair of, by oversewing of abdominal aorta, rep rafting (Anaes.) (Assist.)	air of duodenum and
<b>Fee</b> 34166	Fee: \$2,973.30	<b>Benefit:</b> 75% = \$2230.00	
	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.)		
Fee 34169	Fee: \$1,651.10	<b>Benefit:</b> 75% = \$1238.35	
	INFECTED AXIL arteries (Anaes.) (A	LO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of Assist.)	, including closure of
Fee 34172	Fee: \$1,345.80	<b>Benefit:</b> 75% = \$1009.35	
	INFECTED BYPA (Anaes.) (Assist.)	ASS GRAFT FROM EXTREMITIES, excision of including closu	re of arteries
Fee 34175	Fee: \$1,236.35	<b>Benefit:</b> 75% = \$927.30	
		OPERATIONS FOR VASCULAR ACCESS	
	ARTERIOVENO	US SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.)	
Fee 34500	Fee: \$320.90	<b>Benefit:</b> 75% = \$240.70 85% = \$272.80	
Ess	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.)		
Fee 34503	Fee: \$430.30	<b>Benefit:</b> 75% = \$322.75	
	ARTERIOVENO	US SHUNT, EXTERNAL, removal of (Anaes.) (Assist.)	
Fee 34506	Fee: \$218.95	<b>Benefit:</b> 75% = \$164.25	
	ARTERIOVENO	US ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conj arterial operation (Anaes.) (Assist.)	unction with
<b>Fee</b> 34509	Fee: \$1,017.15	<b>Benefit:</b> 75% = \$762.90	
	ARTERIOVENO	US ACCESS DEVICE, insertion of (Anaes.) (Assist.)	
<b>Fee</b> 34512	Fee: \$1,119.00	<b>Benefit:</b> 75% = \$839.25	

T8. SUR	GICAL OPERATI	ONS		3. VASCULAR
	ARTERIOVENO	US ACCESS DEVICE, throm	bectomy of (Anaes.) (Assist.)	
Fee 34515	Fee: \$798.05	<b>Benefit:</b> 75% = \$598.55		
_		RTERIOVENOUS FISTULA ion of (Anaes.) (Assist.)	OR PROSTHETIC ARTERIOVE	ENOUS ACCESS
Fee 34518	Fee: \$1,337.85	<b>Benefit:</b> 75% = \$1003.40		
		INAL ARTERY OR VEIN, ca ing aftercare) (Anaes.) (Assist.	nnulation of, for infusion chemot	herapy, by open
<b>Fee</b> 34521	(See para TN.8.4 of <b>Fee:</b> \$822.00	explanatory notes to this Categor Benefit: 75% = \$616.50	y)	
		NULATION for infusion cher applies (excluding after-care)	notherapy by open operation, not (Anaes.) (Assist.)	being a service to
<b>Fee</b> 34524	(See para TN.8.4 of <b>Fee:</b> \$430.30	explanatory notes to this Category Benefit: 75% = \$322.75	y)	
Amend	access port as wit	h central venous line catheter of	en technique, using subcutaneous or other chemotherapy delivery de ion, on a patient 10 years of age c	vice, including any
Fee 34527	Fee: \$573.95	<b>Benefit:</b> 75% = \$430.50 85	5% = \$489.25	
Amend Fee	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a patient 10 years of age or over (Anaes.)			
34528	Fee: \$283.45	<b>Benefit:</b> 75% = \$212.60 85	5% = \$240.95	
Amend Fee	access port as wit	h central venous line catheter o	en technique, using subcutaneous or other chemotherapy delivery de ion, on a patient under 10 years o	vice, including any
34529	Fee: \$746.15	<b>Benefit:</b> 75% = \$559.65 85	5% = \$661.45	
Amend Fee			MOTHERAPY DEVICE, remova on a patient 10 years of age or ove	
34530	Fee: \$212.50	<b>Benefit:</b> 75% = \$159.40 85	5% = \$180.65	
	procedure, region		nulation of artery and vein at com or other therapy, repair of arterio (Assist.)	
Fee 34533	Fee: \$1,290.90	<b>Benefit:</b> 75% = \$968.20 85	5% = \$1206.20	
Amend	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a patient under 10 years of age (Anaes.)			
Fee 34534	Fee: \$368.45	<b>Benefit:</b> 75% = \$276.35 85	5% = \$313.20	
	CENTRAL VEIN		ercutaneous technique, using subo stration of haemodialysis or paren	
Fee 34538	Fee: \$283.45	<b>Benefit:</b> 75% = \$212.60 85	5% = \$240.95	
Fee	TUNNELLED C	UFFED CATHETER OR SIM	ILAR DEVICE, removal of, by o	pen surgical procedure

T8. SUR	GICAL OPERATI	ONS 3. VASCULAR
34539	(Anaes.)	
	Fee: \$212.50	<b>Benefit:</b> 75% = \$159.40 85% = \$180.65
Amend		OUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical perating theatre of a hospital, on a patient under 10 years of age (Anaes.)
Fee	-	
34540	Fee: \$276.25	<b>Benefit:</b> 75% = \$207.20 85% = \$234.85
		COMPLEX VENOUS OPERATIONS
Fee	INFERIOR VEN	A CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.)
34800	Fee: \$845.10	<b>Benefit:</b> 75% = \$633.85 85% = \$760.40
	INFERIOR VEN	A CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.)
Fee 34803	Fee: \$1,862.40	<b>Benefit:</b> 75% = \$1396.80
54005		PASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.)
Fee		
34806	Fee: \$1,009.35	<b>Benefit:</b> 75% = \$757.05
Eas	SAPHENOUS VI (Assist.)	EIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.)
Fee 34809	Fee: \$1,009.35	<b>Benefit:</b> 75% = \$757.05
	VENOUS STEN	OSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a
	service associated	with a service to which item 34806 or 34809 applies (Anaes.) (Assist.)
Fee 34812	Fee: \$1,220.60	<b>Benefit:</b> 75% = \$915.45
	VEIN STENOSIS (Anaes.) (Assist.)	s, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material
Fee	(See para TN.8.36 c	of explanatory notes to this Category)
34815	<b>Fee:</b> \$1,009.35	<b>Benefit:</b> 75% = \$757.05
	VENOUS VALV	E, plication or repair to restore valve competency (Anaes.) (Assist.)
Fee 34818	Fee: \$1,111.05	<b>Benefit:</b> 75% = \$833.30
54010		ANT to restore valvular function (Anaes.) (Assist.)
Fee		
34821	Fee: \$1,510.20	<b>Benefit:</b> 75% = \$1132.65 85% = \$1425.50
	EXTERNAL STE (Anaes.) (Assist.)	ENT, application of, to restore venous valve competency to superficial vein - 1 stent
<b>Fee</b> 34824	Fee: \$516.40	<b>Benefit:</b> 75% = \$387.30
	EXTERNAL STE	ENTS, application of, to restore venous valve competency to superficial vein or veins -
T.	more than 1 stent	(Anaes.) (Assist.)
<b>Fee</b> 34827	Fee: \$626.05	<b>Benefit:</b> 75% = \$469.55
	EXTERNAL STE (Assist.)	ENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.)
<b>Fee</b> 34830	Fee: \$735.60	<b>Benefit:</b> 75% = \$551.70 85% = \$650.90
<b>Fee</b> 34833	EXTERNAL STE	ENTS, application of, to restore venous valve competency to deep vein or veins (more

T8. SUF	RGICAL OPERAT	IONS	3. VASCULAR
	than 1 stent) (An	aes.) (Assist.)	
	Fee: \$954.60	<b>Benefit:</b> 75% = \$715.95	
		SYMPATHECT	OMY
	LUMBAR SYM	PATHECTOMY (Anaes.) (Assist.)	
Fee 35000	Fee: \$735.60	<b>Benefit:</b> 75% = \$551.70 85% = \$650.	90
Fee	CERVICAL OR (Assist.)	UPPER THORACIC SYMPATHECTO	MY by any surgical approach (Anaes.)
35003	Fee: \$954.60	<b>Benefit:</b> 75% = \$715.95	
		UPPER THORACIC SYMPATHECTOR lete sympathectomy by any surgical appro-	MY, where operation is a reoperation for oach (Anaes.) (Assist.)
Fee 35006	Fee: \$1,197.20	<b>Benefit:</b> 75% = \$897.90	
Fee	LUMBAR SYM	PATHECTOMY, where operation is follo lete surgical sympathectomy (Anaes.) (A	
35009	Fee: \$931.00	<b>Benefit:</b> 75% = \$698.25	
	SACRAL or PRI	E-SACRAL SYMPATHECTOMY (Anae	es.) (Assist.)
Fee 35012	Fee: \$735.60	<b>Benefit:</b> 75% = \$551.70	
		DEBRIDEMENT AND AMPUTATIONS	FOR VASCULAR DISEASE
		MB, debridement of necrotic material, ga tal, when debridement includes muscle, t	angrenous tissue, or slough in, in the operating tendon or bone (Anaes.) (Assist.)
<b>Fee</b> 35100	<b>Fee:</b> \$383.45	<b>Benefit:</b> 75% = \$287.60	
Fee		MB, debridement of necrotic material, ga tal, superficial tissue only (Anaes.)	ngrenous tissue, or slough in, in the operating
35103	Fee: \$244.05	<b>Benefit:</b> 75% = \$183.05	
		MISCELLANEOUS VASCULA	AR PROCEDURES
		RTERIOGRAPHY OR VENOGRAPHY, edure on an artery or vein, 1 site (Anaes.	, 1 or more of, performed during the course of
Fee 35200	Fee: \$178.45	<b>Benefit:</b> 75% = \$133.85	
-		IES OR VEINS IN THE NECK, ABDO N after prior surgery on these vessels (An	MEN OR EXTREMITIES, access to, as part of aaes.) (Assist.)
Fee 35202	Fee: \$850.20	<b>Benefit:</b> 75% = \$637.65	
		ENDOVASCULAR INTERVENTION	ONAL PROCEDURES
T		ure, excluding associated radiological ser	cripheral artery or vein of 1 limb, percutaneous rvices or preparation, and excluding aftercare
Fee 35300	Fee: \$536.25	<b>Benefit:</b> 75% = \$402.20 85% = \$455.	85
<b>Fee</b> 35303	TRANSLUMINA more than 1 perip	AL BALLOON ANGIOPLASTY of aorti	ic arch branches, aortic visceral branches, or ous or by open exposure, excluding associated

T8. SUF	RGICAL OPERAT	IONS	3. VASCULAR
	Fee: \$687.55	<b>Benefit:</b> 75% = \$515.70 85% = \$602.85	
F	peripheral artery	AL STENT INSERTION, 1 or more stents, including or vein of 1 limb, percutaneous or by open exposure, ration, and excluding aftercare. (Anaes.) (Assist.)	
Fee 35306	Fee: \$634.60	<b>Benefit:</b> 75% = \$475.95 85% = \$549.90	
	associated balloo	AL STENT INSERTION, 1 or more stents (not drug-e on dilatation, for 1 carotid artery, percutaneous (not dir on device, in patients who:	
	- meet the indi	cations for carotid endarterectomy; and	
		or surgical comorbidities that would make them at higom carotid endarterectomy,	gh risk of perioperative
	excluding associ	ated radiological services or preparation, and excludin	g aftercare (Anaes.) (Assist.)
<b>Fee</b> 35307	(See para TN.8.37 <b>Fee:</b> \$1,166.60	of explanatory notes to this Category) Benefit: 75% = \$874.95	
	visceral arteries	AL STENT INSERTION, 1 or more stents, including a or veins, or more than 1 peripheral artery or vein of 1 l ling associated radiological services or preparation, an	limb, percutaneous or by open
Fee 35309	Fee: \$793.25	<b>Benefit:</b> 75% = \$594.95 85% = \$708.55	
_	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)		
Fee 35312	Fee: \$899.00	<b>Benefit:</b> 75% = \$674.25	
PERIPHERAL LASER ANGIOPLASTY including associated balloon dila or by open exposure, excluding associated radiological services or preparat (Anaes.) (Assist.)			
Fee 35315	Fee: \$899.00	<b>Benefit:</b> 75% = \$674.25	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excludin 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 an not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)		ercutaneous approach, excluding (not being a service associated ems 35319 or 35320 applies and
<b>Fee</b> 35317	(See para TN.8.38 <b>Fee:</b> \$370.20	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$277.65 85% = \$314.70	
	or chemotherape excluding associ associated with a	ARTERIAL OR VENOUS CATHETERISATION with utic agents, BY PULSE SPRAY TECHNIQUE, using ated radiological services or preparation, and excludin a service to which another item in Subgroup 11 of Gro being a service associated with photodynamic therapy	percutaneous approach, g aftercare (not being a service up T1 or items 35317 or 35320
Fee 35319	Fee: \$663.60	<b>Benefit:</b> 75% = \$497.70 85% = \$578.90	
Fee	PERIPHERAL A	ARTERIAL OR VENOUS CATHETERISATION with	h administration of thrombolytic

T8. SUF	GICAL OPERATIONS	3. VASCULAR
35320	or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated radio preparation, and excluding aftercare (not being a service associated with a servic in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a ser photodynamic therapy with verteporfin) (Anaes.) (Assist.)	e to which another item
	<b>Fee:</b> \$891.40 <b>Benefit:</b> 75% = \$668.55 85% = \$806.70	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for the fibroids or varicose veins) percutaneous or by open exposure, excluding associat or preparation, and excluding aftercare, not being a service associated with photo verteporfin (Anaes.) (Assist.)	e treatment of uterine ed radiological services
<b>Fee</b> 35321	(See para TN.8.32 of explanatory notes to this Category)           Fee: \$846.25         Benefit: 75% = \$634.70         85% = \$761.55	
F	ANGIOSCOPY not combined with any other procedure, excluding associated ra preparation, and excluding aftercare (Anaes.) (Assist.)	diological services or
Fee 35324	<b>Fee:</b> \$317.35 <b>Benefit:</b> 75% = \$238.05	
Fee	ANGIOSCOPY combined with any other procedure, excluding associated radiol preparation, and excluding aftercare (Anaes.) (Assist.)	ogical services or
35327	<b>Fee:</b> \$425.30 <b>Benefit:</b> 75% = \$319.00	
	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open	
Fee	associated radiological services or preparation, and excluding aftercare (Anaes.)	(Assist.)
35330	Fee: \$536.25         Benefit: 75% = \$402.20         85% = \$455.85	
Fee	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open including associated radiological services or preparation, and not including after	
35331	<b>Fee:</b> \$616.50 <b>Benefit:</b> 75% = \$462.40	
	Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open associated radiological services or preparation, and not including aftercare	exposure, not including
Fee	(foreign body does not include an instrument inserted for the purpose of a servic (Anaes.) (Assist.)	e being rendered)
35360	Fee: \$861.75         Benefit: 75% = \$646.35	
	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposur associated radiological services or preparation, and not including aftercare	e, not including
Fee	(foreign body does not include an instrument inserted for the purpose of a service (Anaes.) (Assist.)	e being rendered)
35361	<b>Fee:</b> \$739.05 <b>Benefit:</b> 75% = \$554.30	
Fee	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneou not including associated radiological services or preparation, and not including a	• • •
35362		

T8. SUF	RGICAL OPERATIONS 3. VASCULA
	(foreign body does not include an instrument inserted for the purpose of a service being rendered) (Anaes.) (Assist.)
	<b>Fee:</b> \$616.50 <b>Benefit:</b> 75% = \$462.40
	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or by operation, and not including associated radiological services or preparation, and not including aftercare
Fee	(foreign body does not include an instrument inserted for the purpose of a service being rendered) (Anaes.) (Assist.)
Fee 35363	<b>Fee:</b> \$493.90 <b>Benefit:</b> 75% = \$370.45
	INTERVENTIONAL RADIOLOGY PROCEDURES
	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective internal radiation therapy of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovori not being a service to which item 35317, 35319, 35320 or 35321 applies
	The procedure must be performed by a specialist or consultant physician recognised in the specialties o nuclear medicine or radiation oncology on an admitted patient in a hospital. To be claimed once in the patient's lifetime only.
<b>Fee</b> 35404	(See para TN.3.1, TN.8.40 of explanatory notes to this Category)Fee: $$360.65$ Benefit: $75\% = $270.50$
	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies
	excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
<b>Fee</b> 35406	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) <b>Fee:</b> \$846.25 <b>Benefit:</b> 75% = \$634.70
	Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer SIR- Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal canc and are not suitable for resection or ablation, for selective internal radiation therapy used in combinatio with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies
	excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
<b>Fee</b> 35408	(See para TN.3.1, TN.8.40 of explanatory notes to this Category)Fee: $$634.80$ Benefit: $75\% = $476.10$
	UTERINE ARTERY CATHETERISATION with percutaneous administration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, ar excluding aftercare (Anaes.) (Assist.)
<b>Fee</b> 35410	(See para TN.8.34 of explanatory notes to this Category) <b>Fee:</b> $846.25$ <b>Benefit:</b> $75\% = 634.70$ $85\% = 761.55$

	RGICAL OPERATIONS	3. VASCULAR
	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with d assisted coiling if performed, with parent artery preservation, not for use with including aftercare, including intra-operative imaging, but in association with operative diagnostic imaging items:	liquid embolics only,
	- either 60009 or 60010; and	
	- either 60072, 60073, 60075, 60076, 60078 or 60079 (Anaes.) (Assist.)	
<b>Fee</b> 35412	(See para TN.8.35 of explanatory notes to this Category) <b>Fee:</b> \$2,973.30 <b>Benefit:</b> 75% = \$2230.00 85% = \$2888.60	
	Mechanical thrombectomy, in a patient with a diagnosis of acute ischaemic st of a large vessel of the anterior cerebral circulation, including intra-operative	
	(a) the diagnosis is confirmed by an appropriate imaging modality such as con magnetic resonance imaging or angiography; and	nputed tomography,
	(b) the service is performed by a specialist or consultant physician with appro recognised by the Conjoint Committee for Recognition of Training in Interver and	
	(c) the service is provided in an eligible stroke centre.	
	For any particular patient - applicable once per presentation by the patient at a regardless of the number of times mechanical thrombectomy is attempted dur (Anaes.) (Assist.)	
<b>Fee</b> 35414	(See para TR.8.1 of explanatory notes to this Category) <b>Fee:</b> \$3,641.85 <b>Benefit:</b> 75% = \$2731.40	
T8. SUF	RGICAL OPERATIONS	4. GYNAECOLOGICAL
	Group T8. Surgical Operations	
	Group T8. Surgical Operations Subgroup 4. Gynaecological	
		g a service associated with
<b>Fee</b> 35500	Subgroup 4. Gynaecological GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not beir	g a service associated with
35500	Subgroup 4. Gynaecological           GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not beir a service to which another item in this Group applies (Anaes.)	hic menorrhagia, AND
35500	Subgroup 4. Gynaecological         GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not bein a service to which another item in this Group applies (Anaes.)         Fee: \$84.60         Benefit: 75% = \$63.45         85% = \$71.95         INTRAUTERINE DEVICE, INTRODUCTION OF, for the control of idiopate ENDOMETRIAL BIOPSY to exclude endometrial pathology, not being a service and the service of the	hic menorrhagia, AND
35500 Fee	Subgroup 4. Gynaecological         GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not bein a service to which another item in this Group applies (Anaes.)         Fee: \$84.60       Benefit: 75% = \$63.45       85% = \$71.95         INTRAUTERINE DEVICE, INTRODUCTION OF, for the control of idiopate ENDOMETRIAL BIOPSY to exclude endometrial pathology, not being a ser service to which another item in this Group applies (Anaes.)         Fee: \$83.40       Benefit: 75% = \$62.55       85% = \$70.90         Intra uterine contraceptive device, introduction of, if the service is not associal	hic menorrhagia, AND vice associated with a ted with a service to which
35500 Fee 35502 Fee	Subgroup 4. Gynaecological           GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not beir a service to which another item in this Group applies (Anaes.)           Fee: \$84.60         Benefit: 75% = \$63.45         85% = \$71.95           INTRAUTERINE DEVICE, INTRODUCTION OF, for the control of idiopate ENDOMETRIAL BIOPSY to exclude endometrial pathology, not being a ser service to which another item in this Group applies (Anaes.)           Fee: \$83.40         Benefit: 75% = \$62.55         85% = \$70.90           Intra uterine contraceptive device, introduction of, if the service is not associal another item in this Group applies (other than a service mentioned in item 300	hic menorrhagia, AND vice associated with a ted with a service to which
35500 Fee 35502	Subgroup 4. Gynaecological         GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not bein a service to which another item in this Group applies (Anaes.)         Fee: \$84.60       Benefit: 75% = \$63.45       85% = \$71.95         INTRAUTERINE DEVICE, INTRODUCTION OF, for the control of idiopate ENDOMETRIAL BIOPSY to exclude endometrial pathology, not being a ser service to which another item in this Group applies (Anaes.)         Fee: \$83.40       Benefit: 75% = \$62.55       85% = \$70.90         Intra uterine contraceptive device, introduction of, if the service is not associal	hic menorrhagia, AND vice associated with a ted with a service to which 062) (Anaes.) GENERAL

T8. SUF		IONS	4. GYNAECOLOGICAL
P	nerve block (excl	uding pudendal block) requ	al of under general anaesthesia, or under regional or field uiring admission to a hospital, where the time taken is less rvice associated with a service to which item 32177 or 32180
Fee 35507	Fee: \$181.50	<b>Benefit:</b> 75% = \$136.15	5 85% = \$154.30
Fee	nerve block (excl	luding pudendal block) requisition requisition in the second se	al of under general anaesthesia, or under regional or field uiring admission to a hospital, where the time taken is e associated with a service to which item 32177 or 32180
35508	Fee: \$267.35	<b>Benefit:</b> 75% = \$200.55	5 85% = \$227.25
	HYMENECTON	IY (Anaes.)	
Fee 35509	Fee: \$93.10	<b>Benefit:</b> 75% = \$69.85	85% = \$79.15
	BARTHOLIN'S	CYST, excision of (Anaes.	)
Fee 35513	Fee: \$230.70	<b>Benefit:</b> 75% = \$173.05	5 85% = \$196.10
		CYST OR GLAND, marsu	
<b>Fee</b> 35517	Fee: \$151.95	<b>Benefit:</b> 75% = \$114.00	85% = \$129.20
	least 2cm in dian	neter in a postmenopausal p	of at least 4cm in diameter in a premenopausal person and at person, by abdominal or vaginal route, using interventional services provided for assisted reproductive techniques
<b>Fee</b> 35518	(See para TN.4.11 <b>Fee:</b> \$216.30	of explanatory notes to this Ca Benefit: 75% = \$162.25	
1	BARTHOLIN'S	ABSCESS, incision of (An	aes.)
Fee 35520	Fee: \$60.70	<b>Benefit:</b> 75% = \$45.55	85% = \$51.60
	URETHRA OR U	URETHRAL CARUNCLE	, cauterisation of (Anaes.)
Fee 35523	Fee: \$60.70	<b>Benefit:</b> 75% = \$45.55	85% = \$51.60
	URETHRAL CA	RUNCLE, excision of (An	naes.)
<b>Fee</b> 35527	Fee: \$151.95	<b>Benefit:</b> 75% = \$114.00	) 85% = \$129.20
	CLITORIS, amp	utation of, where medically	v indicated (Anaes.) (Assist.)
Fee 35530	Fee: \$280.75	<b>Benefit:</b> 75% = \$210.60	)
	Vulvoplasty or la	bioplasty, for repair of:	
	(a) female genital mutilation; or		
	(b) an anomaly associated with a major congenital anomaly of the uro-gynaecological tract		
	other than a servi 43882 applies (A		e to which item 35536, 37836, 37050, 37842, 37851 or
<b>Fee</b> 35533	(See para TN.8.123 <b>Fee:</b> \$364.05	3 of explanatory notes to this C Benefit: 75% = \$273.05	
Fee			1 18 years or more, performed by a specialist in the practice

T8. SUF	RGICAL OPERAT	IONS	4. GYNAECOLOGICAL
35534	if the patient's la	specialty, for a structural abnormality that is c bium extends more than 8 cm below the vagina position (Anaes.)	
	(See para TN.8.12 <b>Fee:</b> \$364.05	3 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$273.05	
	VULVA, wide lo (Anaes.) (Assist.	ocal excision of suspected malignancy or hemi-	vulvectomy, 1 or both procedures
<b>Fee</b> 35536	Fee: \$362.60	<b>Benefit:</b> 75% = \$271.95 85% = \$308.25	
2	neoplastic chang	ALLY DIRECTED CO <sup>2</sup> LASER THERAPY f es of the cervix, vagina, vulva, urethra or anal mical site (Anaes.)	
Fee 35539	Fee: \$284.00	<b>Benefit:</b> 75% = \$213.00 85% = \$241.40	
Fee	neoplastic chang	ALLY DIRECTED CO <sup>2</sup> LASER THERAPY f ges of the cervix, vagina, vulva, urethra or anal ore anatomical sites (Anaes.) (Assist.)	1 1
35542	Fee: \$332.50	<b>Benefit:</b> 75% = \$249.40 85% = \$282.65	
	COLPOSCOPIC by other method	ALLY DIRECTED CO <sup>2</sup> LASER THERAPY f s (Anaes.)	for condylomata, unsuccessfully treated
Fee 35545	Fee: \$191.05	<b>Benefit:</b> 75% = \$143.30 85% = \$162.40	
	VULVECTOMY	, radical, for malignancy (Anaes.) (Assist.)	
<b>Fee</b> 35548	Fee: \$867.85	<b>Benefit:</b> 75% = \$650.90	
		des, radical excision of, unilateral, or sentinel n on) (Anaes.) (Assist.)	node dissection (including any pre-
Fee 35551	Fee: \$962.20	<b>Benefit:</b> 75% = \$721.65	
	Pelvic lymph no chemotherapy (A	des, radical excision of, unilateral, following si Anaes.) (Assist.)	milar previous dissection, radiation or
Fee 35552	<b>Fee:</b> \$1,447.50	<b>Benefit:</b> 75% = \$1085.65	
T	VAGINA, DILA (Anaes.)	TATION OF, as an independent procedure inc	eluding any associated consultation
Fee 35554	Fee: \$45.25	<b>Benefit:</b> 75% = \$33.95 85% = \$38.50	
	VAGINA, remov	val of simple tumour (including Gartner duct cy	yst) (Anaes.)
<b>Fee</b> 35557	Fee: \$223.20	<b>Benefit:</b> 75% = \$167.40 85% = \$189.75	
	VAGINA, partial or complete removal of (Anaes.) (Assist.)		
Fee 35560	<b>Fee:</b> \$711.60 <b>Benefit:</b> 75% = \$533.70		
		Y, radical, for proven invasive malignancy - 1	surgeon (Anaes.) (Assist.)
<b>Fee</b> 35561	<b>Fee:</b> \$1,435.35	<b>Benefit:</b> 75% = \$1076.55	
<b>Fee</b> 35562		Y, radical, for proven invasive malignancy, con are) (Anaes.) (Assist.)	njoint surgery - abdominal surgeon

T8. SUF	RGICAL OPERATI	ONS	4. GYNAECOLOGICAL
	Fee: \$1,178.45	<b>Benefit:</b> 75% = \$883.85	
	VAGINECTOM	, radical, for proven invasive ma	lignancy, conjoint surgery - perineal surgeon (Assist.)
Fee 35564	<b>Fee:</b> \$544.00	<b>Benefit:</b> 75% = \$408.00	
	VAGINAL RECO	DNSTRUCTION for congenital a	bsence, gynatresia or urogenital sinus (Anaes.)
Fee	(Assist.)		
35565	Fee: \$711.60	<b>Benefit:</b> 75% = \$533.70	
Б	VAGINAL SEPT	UM, excision of, for correction of	f double vagina (Anaes.) (Assist.)
Fee 35566	Fee: \$413.35	<b>Benefit:</b> 75% = \$310.05	
	SACROSPINOU (Assist.)	S COLPOPEXY FOR MANAGE	EMENT OF UPPER VAGINAL PROLAPSE (Anaes.)
Fee 35568	<b>Fee:</b> \$649.90	<b>Benefit:</b> 75% = \$487.45	
55500		R TO ENLARGE VAGINAL O	RIFICE (Anaes.)
<b>Fee</b> 35569	Fee: \$167.35	<b>Benefit:</b> 75% = \$125.55	
33309			proach for pelvic organ prolapse:
	C C		
	(a) involving repair of urethrocele and cystocele; and		
	(b) using native tissue without graft;		
	other than a servio (Assist.)	ce associated with a service to wh	nich item 35573, 35577 or 35578 applies (Anaes.)
Fee		D Ct. 750/ 0100.05	
35570	Fee: \$576.30	<b>Benefit:</b> 75% = \$432.25	proach for polyic organ prolonse:
	Posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse:		
	(a) involving repa	ir of one or more of the following	g:
	(i) perineum	ι;	
	(ii) rectocoe	le;	
	(iii) enterocoele; and		
	(b) using native tissue without graft;		
	other than a servic (Assist.)	ce associated with a service to wh	nich item 35573, 35577 or 35578 applies (Anaes.)
Fee 25571	Fee: \$576.30	<b>Benefit:</b> 75% = \$432.25	
35571			her item in this Group applies (Anaes.)
<b>Fee</b> 35572	<b>Fee:</b> \$128.85	<b>Benefit:</b> 75% = \$96.65	ter tem in this Group applies (r thes.)
	Anterior and post	erior vaginal compartment repair	by vaginal approach for pelvic organ prolapse:
	(a) involving ante	rior and posterior compartment d	efects; and
<b>Fee</b> 35573	(b) using native ti	ssue without graft;	

T8. SUF	RGICAL OPERATIONS 4. GYNAECOLOGIC	CAL
	other than a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.	)
	<b>Fee:</b> \$864.55 <b>Benefit:</b> 75% = \$648.45	
	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.)	
Fee 35577	<b>Fee:</b> \$701.85 <b>Benefit:</b> 75% = \$526.40	
	LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.)	
<b>Fee</b> 35578	<b>Fee:</b> \$701.85 <b>Benefit:</b> 75% = \$526.40	
	Vaginal procedure for excision of graft material in symptomatic patients with graft related complicate (including graft related pain or discharge and bleeding related to graft exposure), less than 2cm <sup>2</sup> in its maximum area, either singly or in multiple pieces, other than a service associated with a service to w item 35582 or 35585 applies	s
	(Anaes.) (Assist.)	
Fee 35581	(See para TN.8.140 of explanatory notes to this Category) <b>Fee:</b> \$576.30 <b>Benefit:</b> 75% = \$432.25	
	Vaginal procedure for excision of graft material in symptomatic patients with graft related complicat (including graft related pain or discharge and bleeding related to graft exposure), 2cm <sup>2</sup> or more in its maximum area, either singly or in multiple pieces, other than a service associated with a service to w item 35581 or 35585 applies (Anaes.) (Assist.)	
<b>Fee</b> 35582	(See para TN.8.140 of explanatory notes to this Category) <b>Fee:</b> \$864.55 <b>Benefit:</b> 75% = \$648.45	
	Abdominal procedure, by open, laparoscopic or robot-assisted 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 bo and	wel;
	(b) if required—includes retroperitoneal dissection, and mobilisation, of either or both of the bladder bowel;	and
	other than a service associated with a service to which item 35581 or 35582 applies	
	(Anaes.) (Assist.)	
Fee 35585	<b>Fee:</b> \$1,532.85 <b>Benefit:</b> 75% = \$1149.65	
<b>Fee</b> 35595	LAPAROSCOPIC OR ABDOMINAL PELVIC FLOOR REPAIR INCORPORATING THE FIXATION OF THE UTEROSACRAL AND CARDINAL LIGAMENTS TO RECTOVAGINAL A	ND

T8. SUF	RGICAL OPERAT	IONS	4. GYNAECOLOGICAL
	PUBOCERVIC	AL FASCIA for symptomatic up	oper vaginal vault prolapse (Anaes.) (Assist.)
	Fee: \$1,201.80	<b>Benefit:</b> 75% = \$901.35	
_		WEEN GENITAL AND URINA ch item 37029, 37333 or 37336	ARY OR ALIMENTARY TRACTS, repair of, not being applies (Anaes.) (Assist.)
Fee 35596	Fee: \$711.60	<b>Benefit:</b> 75% = \$533.70	
		mpartment and to sacrum for co	procedure where graft or mesh secured to vault, anterior rrection of symptomatic upper vaginal vault prolapse
Fee 35597	Fee: \$1,532.85	<b>Benefit:</b> 75% = \$1149.65	
	assess the integr		In the tic mid-ure thral sling, with diagnostic cystoscopy to her than a service associated with a service to which item
Fee 35599	Fee: \$788.60	<b>Benefit:</b> 75% = \$591.45	
	procedure, with		nous ABDOMINOVAGINAL operation for; abdominal ercare), not being a service associated with a service to
Fee 35602	Fee: \$701.85	<b>Benefit:</b> 75% = \$526.40	
	procedure, with		nous ABDOMINOVAGINAL operation for; vaginal ercare), not being a service associated with a service to
Fee 35605	Fee: \$380.80	<b>Benefit:</b> 75% = \$285.60 85	5% = \$323.70
_		risation (other than by chemical on of cervix (Anaes.)	means), ionisation, diathermy or biopsy of, with or
Fee 35608	Fee: \$66.55	<b>Benefit:</b> 75% = \$49.95 859	% = \$56.60
		val of polyp or polypi, with or w which item 35608 applies (Ana	ithout dilatation of cervix, not being a service associated ass.)
Fee 35611	Fee: \$66.55	<b>Benefit:</b> 75% = \$49.95 859	% = \$56.60
			abdominal approach (Anaes.) (Assist.)
Fee 35612	Fee: \$526.50	<b>Benefit:</b> 75% = \$394.90 83	5% - \$/1/7 55
55012			vaginal approach (Anaes.) (Assist.)
<b>Fee</b> 35613	<b>Fee:</b> \$421.20	<b>Benefit:</b> 75% = \$315.90	vaginar approach (r macs.) (r issist.)
	abnormal cervic	al smear screen result or a histor	nselmanntype colposcope in a patient with a previous ry of maternal ingestion of oestrogen or where a patient, referred by another medical practitioner (Anaes.)
<b>Fee</b> 35614	(See para TN.8.42 <b>Fee:</b> \$66.45	2 of explanatory notes to this Categorian <b>Benefit:</b> $75\% = $49.85$	
	VULVA, biopsy	of, when performed in conjunc	tion with a service to which item 35614 applies
Fee 35615	Fee: \$55.85	<b>Benefit:</b> 75% = \$41.90 859	% = \$47.50
	1		

T8. SUF	RGICAL OPERAT	IONS	4. GYNAECOLOGICA
35616	radiofrequency electrosurgery, for chronic rel performed on the same day, with or without u		actory menorrhagia including any hysteroscopy erine curettage (Anaes.)
	Fee: \$467.80	<b>Benefit:</b> 75% = \$350.85	
	CERVIX, cone b applies (Anaes.)	biopsy, amputation or repair of,	, other than a service to which item 35577 or 35578
Fee 35618	Fee: \$226.80	<b>Benefit:</b> 75% = \$170.10 8	35% = \$192.80
35010	ENDOMETRIA		is suspected in patients with abnormal uterine bleeding o
Fee 35620	Fee: \$55.50	<b>Benefit:</b> 75% = \$41.65 85	5% = \$47.20
	including any hy		laser or diathermy, for chronic refractory menorrhagia ame day, with or without uterine curettage, not being a 30390 applies (Anaes.)
Fee 35622	Fee: \$626.90	<b>Benefit:</b> 75% = \$470.20	
	HYSTEROSCO	PIC RESECTION of myoma, o owed by endometrial ablation b	or myoma and uterine septum resection (where both are by laser or diathermy (Anaes.)
Fee 35623	Fee: \$852.45	<b>Benefit:</b> 75% = \$639.35	
	where the patien	t is referred to him or her for th	ed by a specialist in the practice of his or her specialty ne investigation of suspected intrauterine pathology (with e associated with a service to which item 35627 or 35630
<b>Fee</b> 35626	(See para TN.8.43 <b>Fee:</b> \$86.10	of explanatory notes to this Catego <b>Benefit:</b> 75% = \$64.60 85	-
-			x performed in the operating theatre of a hospital - not ch item 35626 or 35630 applies (Anaes.)
Fee 35627	Fee: \$111.50	<b>Benefit:</b> 75% = \$83.65	
			performed in the operating theatre of a hospital - not bein n 35626 or 35627 applies (Anaes.)
Fee 35630	Fee: \$190.45	<b>Benefit:</b> 75% = \$142.85	
	HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation (including for insertion of device for sterilisation) or removal of IUD which cannot be removed by other means, 1 or more of (Anaes.)		
Fee 35633	Fee: \$226.80	<b>Benefit:</b> 75% = \$170.10 8.	25% = \$192.80
	HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.)		
Fee 35634	Fee: \$713.45	<b>Benefit:</b> 75% = \$535.10 8	55% = \$628.75
		PY involving resection of the u	
Fee 35635	Fee: \$311.60	<b>Benefit:</b> 75% = \$233.70	
<b>Fee</b> 35636	HYSTEROSCO both are perform		oma, or resection of myoma and uterine septum (where

T8. SUF	GICAL OPERATIONS	4. GYNAECOLOGICAL
	<b>Fee:</b> \$450.55 <b>Benefit:</b> 75% =	\$337.95
	of adhesions or similar procedure - 1	re of cysts, diathermy of endometriosis, ventrosuspension, division or more procedures with or without biopsy - not being a service ic procedure or hysterectomy (Anaes.) (Assist.)
<b>Fee</b> 35637	(See para TN.1.4 of explanatory notes to <b>Fee:</b> \$423.10 <b>Benefit:</b> 75% =	
	of the following procedures; oophor salpingostomy, ablation of moderate or division of utero-sacral ligaments	PAROSCOPY, including use of laser when required, for 1 or more ectomy, ovarian cystectomy, myomectomy, salpingectomy or or severe endometriosis requiring more than 1 hours operating time, for significant dysmenorrhoea - not being a service associated with toneal procedure except item 30393 (Anaes.) (Assist.)
Fee 35638	<b>Fee:</b> \$740.35 <b>Benefit:</b> 75% =	\$555.30
	miscarriage) under general anaesthe	or without dilatation (including curettage for incomplete sia, or under epidural or spinal (intrathecal) nerve block, including 527 or 35630 applies, if performed (Anaes.)
<b>Fee</b> 35640	(See para TN.8.44 of explanatory notes <b>Fee:</b> \$190.45 <b>Benefit:</b> 75% =	
E.	following procedures, resection of the tissue from the ureter, resection of the tissue from the ureter, resection of the tissue from the ureter for the tissue from the ureter for the tissue from the ureter for the tissue for the ti	, LAPAROSCOPIC RESECTION OF, involving any two of the ne pelvic side wall including dissection of endometriosis or scar ne Pouch of Douglas, resection of an ovarian endometrioma greater bowel from uterus from the level of the endocervical junction or eeds 90 minutes (Anaes.) (Assist.)
<b>Fee</b> 35641	<b>Fee:</b> \$1,293.05 <b>Benefit:</b> 75% =	\$969.80
F		TS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION o which item 35640 applies, including procedures to which item prormed (Anaes.)
Fee 35643	<b>Fee:</b> \$226.80 <b>Benefit:</b> 75% =	\$170.10 85% = \$192.80
		my with colposcopy, for previously confirmed intraepithelial luding any local anaesthesia and biopsies, other than a service em 35640 or 35647 applies (Anaes.)
<b>Fee</b> 35644	(See para TN.8.45 of explanatory notes <b>Fee:</b> \$211.90 <b>Benefit:</b> 75% =	o this Category) \$158.95 85% = \$180.15
	neoplastic changes of the cervix, inc ablative therapy of additional areas	my with colposcopy, for previously confirmed intraepithelial luding any local anaesthesia and biopsies, in conjunction with of intraepithelial change in 1 or more sites of vagina, vulva, urethra ed with a service to which item 35648 applies (Anaes.)
<b>Fee</b> 35645	(See para TN.8.45 of explanatory notes <b>Fee:</b> \$331.60 <b>Benefit:</b> 75% =	o this Category) \$248.70
	CERVIX, colposcopy with radical d confirmed intraepithelial neoplastic	iathermy of, with or without cervical biopsy, for previously changes of the cervix (Anaes.)
<b>Fee</b> 35646	(See para TN.8.45 of explanatory notes Fee: \$211.90 Benefit: 75% =	o this Category) \$158.95 85% = \$180.15
<b>Fee</b> 35647		sformation zone together with colposcopy for previously confirmed the cervix, including any local anaesthesia and biopsies, not being a

T8. SUR	GICAL OPERATIONS	4. GYNAECOLOGICAL
	service associated with a service to which item 35644 appl	lies (Anaes.)
	(See para TN.8.45 of explanatory notes to this Category) <b>Fee:</b> \$211.90 <b>Benefit:</b> 75% = \$158.95 85% = \$180.	15
	CERVIX, large loop excision diathermy for previously con the cervix, including any local anaesthesia and biopsies, in additional areas of intraepithelial change of 1 or more sites service associated with a service to which item 35645 appl	a conjunction with ablative treatment of s of vagina, vulva, urethra or anus, not being a
<b>Fee</b> 35648	(See para TN.8.45 of explanatory notes to this Category) <b>Fee:</b> \$331.60 <b>Benefit:</b> 75% = \$248.70 85% = \$281.9	90
Fee	HYSTEROTOMY or UTERINE MYOMECTOMY, abdo	minal (Anaes.) (Assist.)
35649	Fee:         \$557.70         Benefit:         75% = \$418.30           UNSTEDECTOMY         ADDOMINAL         SUDTOTAL         27 TOTAL	TAL with on without non-ovel of staring
	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOT adnexae (Anaes.) (Assist.)	TAL, with or without removal of uterme
Fee 35653	<b>Fee:</b> \$702.05 <b>Benefit:</b> 75% = \$526.55	
	HYSTERECTOMY, VAGINAL, with or without uterine of 35673 applies	curettage, not being a service to which item
<b>Fee</b> 35657	NOTE: Strict legal requirements apply in relation to steri benefits are not payable for services not rendered in accor and Territory law. Observe the explanatory note before su(See para TN.8.46 of explanatory notes to this Category)Fee: \$702.05Benefit: 75% = \$526.55	rdance with relevant Commonwealth and State
	UTERUS (at least equivalent in size to a 10 week gravid u at hysterectomy (Anaes.) (Assist.)	tterus), debulking of, prior to vaginal removal
<b>Fee</b> 35658	(See para TN.8.47 of explanatory notes to this Category) <b>Fee:</b> \$432.90 <b>Benefit:</b> 75% = \$324.70	
	HYSTERECTOMY, ABDOMINAL, requiring extensive r exposure of 1 or both ureters, for the management of sever or benign pelvic tumours, with or without conservation of	re endometriosis, pelvic inflammatory disease
Fee 35661	<b>Fee:</b> \$906.65 <b>Benefit:</b> 75% = \$680.00	
	RADICAL HYSTERECTOMY with radical excision of pe uterine adnexae) for proven malignancy including excision upper vagina or contiguous pelvic peritoneum and involvin (Assist.)	n of any 1 or more of parametrium, paracolpos,
Fee 35664	<b>Fee:</b> \$1,511.10 <b>Benefit:</b> 75% = \$1133.35	
	RADICAL HYSTERECTOMY without gland dissection ( for proven malignancy including excision of any 1 or more contiguous pelvic peritoneum and involving ureterolysis w	e of parametrium, paracolpos, upper vagina or
Fee 35667	<b>Fee:</b> \$1,284.25 <b>Benefit:</b> 75% = \$963.20	
<b>Fee</b> 35670	HYSTERECTOMY, abdominal, with radical excision of p	pelvic lymph nodes, with or without removal

T8. SUP	GICAL OPERATIONS	4. GYNAECOLOGICAL	
	of uterine adnexae (Anaes.) (Assist.)		
	<b>Fee:</b> \$1,057.50 <b>Benefit:</b> 75% = \$793.15		
F	HYSTERECTOMY, VAGINAL (with or without ut or excision of ovarian cyst, 1 or more, 1 or both side		
<b>Fee</b> 35673	<b>Fee:</b> \$788.50 <b>Benefit:</b> 75% = \$591.40		
	ULTRASOUND GUIDED NEEDLING and injection	n of ectopic pregnancy	
<b>Fee</b> 35674	(See para TN.4.11 of explanatory notes to this Category) <b>Fee:</b> \$216.30 <b>Benefit:</b> 75% = \$162.25 85% =	\$183.90	
	ECTOPIC PREGNANCY, removal of (Anaes.) (Ass	ist.)	
<b>Fee</b> 35677	<b>Fee:</b> \$557.70 <b>Benefit:</b> 75% = \$418.30		
	ECTOPIC PREGNANCY, laparoscopic removal of	(Anaes.) (Assist.)	
Fee 35678	<b>Fee:</b> \$672.45 <b>Benefit:</b> 75% = \$504.35		
	BICORNUATE UTERUS, plastic reconstruction for	(Anaes.) (Assist.)	
Fee 35680	<b>Fee:</b> \$605.60 <b>Benefit:</b> 75% = \$454.20 85% =	\$520.90	
22000	UTERUS, SUSPENSION OR FIXATION OF, as an		
<b>Fee</b> 35684	<b>Fee:</b> \$490.25 <b>Benefit:</b> 75% = \$367.70		
	STERILISATION BY TRANSECTION OR RESEC vaginal routes or via laparoscopy using diathermy or		
	NOTE: Strict legal requirements apply in relation to benefits are not payable for services not rendered in and Territory law. Observe the explanatory note beg	accordance with relevant Commonwealth and State	
<b>Fee</b> 35688	(See para TN.8.46 of explanatory notes to this Category) <b>Fee:</b> \$413.35 <b>Benefit:</b> 75% = \$310.05		
	STERILISATION BY INTERRUPTION OF FALL with Caesarean section	OPIAN TUBES, when performed in conjunction	
	NOTE: Strict legal requirements apply in relation to benefits are not payable for services not rendered in and Territory law. Observe the explantory note befo	accordance with relevant Commonwealth and State	
<b>Fee</b> 35691	(See para TN.8.46 of explanatory notes to this Category) <b>Fee:</b> \$165.10 <b>Benefit:</b> 75% = \$123.85		
	TUBOPLASTY (salpingostomy, salpingolysis or tub BILATERAL, 1 or more procedures (Anaes.) (Assis	-	
<b>Fee</b> 35694	<b>Fee:</b> \$663.50 <b>Benefit:</b> 75% = \$497.65		
<b>Fee</b> 35697	MICROSURGICAL TUBOPLASTY (salpingostom UNILATERAL or BILATERAL, 1 or more procedu		

T8. SUF		ONS	4. GYNAECOLOGICAL
	Fee: \$984.55	<b>Benefit:</b> 75% = \$738.45	
	FALLOPIAN TU (Assist.)	UBES, unilateral microsurgical a	anastomosis of, using operating microscope (Anaes.)
Fee 35700	Fee: \$759.70	<b>Benefit:</b> 75% = \$569.80	
F			as a nonrepetitive procedure not being a service n this Sub-group applies (Anaes.)
Fee 35703	Fee: \$70.30	<b>Benefit:</b> 75% = \$52.75 85%	б = \$59.80
	RUBIN TEST FO	OR PATENCY OF FALLOPIA	N TUBES (Anaes.)
Fee 35706	Fee: \$70.30	<b>Benefit:</b> 75% = \$52.75 85%	6 = \$59.80
			betitive postoperative procedure (Anaes.)
<b>Fee</b> 35709	Fee: \$45.25	<b>Benefit:</b> 75% = \$33.95 85%	
	FALLOPOSCOF (Assist.)	Y, unilateral or bilateral, inclue	ling hysteroscopy and tubal catheterization (Anaes.)
<b>Fee</b> 35710	Fee: \$482.05	<b>Benefit:</b> 75% = \$361.55	
	OOPHORECTO	MY, removal of OVARIAN, PA	Y, SALPINGECTOMY, SALPINGO- ARAOVARIAN, FIMBRIAL or BROAD LIGAMENT associated with hysterectomy (Anaes.) (Assist.)
<b>Fee</b> 35713	Fee: \$471.20	<b>Benefit:</b> 75% = \$353.40	
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGO- OOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMED CYST - 2 or more such procedures, unilateral or bilateral, other than a service associated with hysterectomy (Anaes.) (Assist.)		ARAOVARIAN, FIMBRIAL or BROAD LIGAMENT
<b>Fee</b> 35717	Fee: \$567.35	<b>Benefit:</b> 75% = \$425.55	
		EBULKING OPERATION for	advanced gynaecological malignancy, with or without
<b>Fee</b> 35720	(See para TN.8.57 <b>Fee:</b> \$701.85	of explanatory notes to this Catego <b>Benefit:</b> 75% = \$526.40	ry)
		NEAL LYMPH NODE BIOPS ng of gynaecological malignan	ES from above the level of the aortic bifurcation, for cy (Anaes.) (Assist.)
Fee 35723	Fee: \$502.70	<b>Benefit:</b> 75% = \$377.05	
F		MENTECTOMY with multiple nalignancy (Anaes.) (Assist.)	e peritoneal biopsies for staging or restaging of
<b>Fee</b> 35726	Fee: \$502.70	<b>Benefit:</b> 75% = \$377.05	
-	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for inva- malignancy (Anaes.)		, in conjunction with radical hysterectomy for invasive
<b>Fee</b> 35729	Fee: \$226.60	<b>Benefit:</b> 75% = \$169.95	
<b>Fee</b> 35730		n the treatment volume and dos	preserve ovarian function, prior to gonadotoxic e of radiation have a high probability of causing

	RGICAL OPERAT	IONS	4. GYNAECOLOGICAL
	Fee: \$226.60	<b>Benefit:</b> 75% = \$169.95	
	LAPAROSCOPI (Anaes.) (Assist.)		CTOMY, including any associated laparoscopy
Fee 35750	Fee: \$816.40	<b>Benefit:</b> 75% = \$612.30	
	procedures: salp	ingectomy, oophorectomy, excis	CTOMY with one or more of the following ion of ovarian cyst or treatment of moderate sociated laparoscopy (Anaes.) (Assist.)
Fee 35753	Fee: \$902.75	<b>Benefit:</b> 75% = \$677.10	
Eas	or other patholog when performed	y, from the ureter, one or both si with one or more of the followin	CTOMY which requires dissection of endometriosis, des, including any associated laparoscopy, including g procedures: salpingectomy, oophorectomy, excision t being a service to which item 35641 applies (Anaes.)
<b>Fee</b> 35754	Fee: \$1,136.15	<b>Benefit:</b> 75% = \$852.15	
	LAPAROSCOPI		CTOMY, when procedure is completed by open py (Anaes.) (Assist.)
<b>Fee</b> 35756	Fee: \$816.40	<b>Benefit:</b> 75% = \$612.30	
<b>Fee</b> 35759	under general an		HAEMORRHAGE following gynaecological surgery, odominal and vaginal approach where no other
	1001 \$5 66.15	<b>Denetite</b> $7570 = 0.05705$	
T8. SUF	RGICAL OPERAT	IONS	5. UROLOGICAL
T8. SUF	GICAL OPERAT		5. UROLOGICAL
T8. SUF	GICAL OPERAT	cal Operations	5. UROLOGICAL
	Group T8. Surgi Suprapubic or persymptomatic patholecting related	cal Operations Subgro prineal procedure for excision of g ient with graft related complication to graft exposure), if not more that	
<b>T8. SUF</b> <b>Fee</b> 37046	Group T8. Surgi Suprapubic or persymptomatic patholecting related	cal Operations Subgro prineal procedure for excision of g ient with graft related complication to graft exposure), if not more that	up 5. Urological graft material, either singly or in multiple pieces, for a ons (including graft related pain or discharge and an one service to which this item applies has been
Fee	Group T8. Surgi Suprapubic or persymptomatic patheling related provided to the provided to the provided to the provided to the prostate or	cal Operations Subgro crineal procedure for excision of g ient with graft related complication to graft exposure), if not more that atient by the same practitioner in Benefit: 75% = \$540.40	up 5. Urological graft material, either singly or in multiple pieces, for a ons (including graft related pain or discharge and an one service to which this item applies has been
Fee	Group T8. Surgi Suprapubic or persymptomatic patheling related provided to the provided to the provided to the provided to the prostate or	Subgro Subgro erineal procedure for excision of g ient with graft related complication to graft exposure), if not more the atient by the same practitioner in <b>Benefit:</b> 75% = \$540.40 atic bed, needle biopsy of, using p	up 5. Urological graft material, either singly or in multiple pieces, for a ons (including graft related pain or discharge and an one service to which this item applies has been the preceding 12 months (Anaes.) (Assist.)
Fee	Group T8. Surgi Suprapubic or pe symptomatic path bleeding related provided to the p Fee: \$720.50 Prostate or prostat obtaining 1 or me	Subgro Subgro erineal procedure for excision of g ient with graft related complication to graft exposure), if not more the atient by the same practitioner in <b>Benefit:</b> 75% = \$540.40 atic bed, needle biopsy of, using p	up 5. Urological graft material, either singly or in multiple pieces, for a ons (including graft related pain or discharge and an one service to which this item applies has been the preceding 12 months (Anaes.) (Assist.)
<b>Fee</b> 37046	Group T8. Surgi Suprapubic or pe symptomatic patt bleeding related provided to the p Fee: \$720.50 Prostate or prostat obtaining 1 or me (Anaes.) (Anaes.)	Subgro Subgro erineal procedure for excision of g ient with graft related complication to graft exposure), if not more the atient by the same practitioner in <b>Benefit:</b> 75% = \$540.40 atic bed, needle biopsy of, using p	up 5. Urological graft material, either singly or in multiple pieces, for a ons (including graft related pain or discharge and an one service to which this item applies has been the preceding 12 months (Anaes.) (Assist.)
Fee 37046 Fee	Group T8. Surgi Suprapubic or pe symptomatic patt bleeding related provided to the p Fee: \$720.50 Prostate or prostat obtaining 1 or me (Anaes.) (Anaes.) (See para TN.8.2 or	Subgro         crineal procedure for excision of grient with graft related complication of grient with graft related complication of graft exposure), if not more that attent by the same practitioner in Benefit: 75% = \$540.40         Benefit: 75% = \$540.40         atic bed, needle biopsy of, using pore prostatic specimens.         of explanatory notes to this Category?         Benefit: 75% = \$219.20       859	up 5. Urological graft material, either singly or in multiple pieces, for a ons (including graft related pain or discharge and an one service to which this item applies has been the preceding 12 months (Anaes.) (Assist.)
Fee 37046 Fee	Group T8. Surgi Suprapubic or pe symptomatic patt bleeding related provided to the p Fee: \$720.50 Prostate or prostat obtaining 1 or me (Anaes.) (Anaes.) (See para TN.8.2 or Fee: \$292.25	Subgro         prineal procedure for excision of gitent with graft related complication to graft exposure), if not more thatient by the same practitioner in         Benefit: 75% = \$540.40         atic bed, needle biopsy of, using pore prostatic specimens.         of explanatory notes to this Category?         Benefit: 75% = \$219.20         859         GE	up 5. Urological graft material, either singly or in multiple pieces, for a ons (including graft related pain or discharge and an one service to which this item applies has been the preceding 12 months (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATIONS 5. UROLOGICA	AL	
-	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.)	)	
Fee 36503	<b>Fee:</b> \$1,447.50 <b>Benefit:</b> 75% = \$1085.65		
F	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.)		
Fee 36506	<b>Fee:</b> \$962.20 <b>Benefit:</b> 75% = \$721.65		
	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.)		
Fee 36509	<b>Fee:</b> \$814.70 <b>Benefit:</b> 75% = \$611.05		
	Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)		
<b>Fee</b> 36516	(See para TN.8.154 of explanatory notes to this Category) <b>Fee:</b> \$962.20 <b>Benefit:</b> 75% = \$721.65		
	Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, complicated by previous surgery on the same kidney, other than a service associated with a service to which item 30390 or 3062 applies (Anaes.) (Assist.)	27	
<b>Fee</b> 36519	(See para TN.8.154 of explanatory notes to this Category)Fee: $$1,343.45$ Benefit: 75% = $$1007.60$		
	Nephrectomy, partial, by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	1	
<b>Fee</b> 36522	(See para TN.8.154 of explanatory notes to this Category) <b>Fee:</b> \$1,152.90 <b>Benefit:</b> 75% = \$864.70		
	Nephrectomy, partial, by open, laparoscopic or robot-assisted approach:		
	(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 60ml/min/1.73m <sup>2</sup> ;		
Б	other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)		
Fee 36525	<b>Fee:</b> \$1,638.25 <b>Benefit:</b> 75% = \$1228.70		
	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cm in diameter, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)		
<b>Fee</b> 36528	(See para TN.8.154 of explanatory notes to this Category) <b>Fee:</b> \$1,343.45 <b>Benefit:</b> 75% = \$1007.60		
	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy:		
	(a) for a tumour 10 cm or more in diameter; or		
	(b) if complicated by previous open or laparoscopic surgery on the same kidney;		
<b>Fee</b> 36529	other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)		

T8. SUF	GICAL OPERATIONS	5. UROLOGICAL
	(See para TN.8.154 of explanatory notes to <b>Fee:</b> \$1,658.00 <b>Benefit:</b> 75% = \$	
		en, laparoscopic or robot-assisted approach, including associated scopic procedure, other than a service associated with a service to naes.) (Assist.)
<b>Fee</b> 36531	(See para TN.8.154 of explanatory notes to <b>Fee:</b> \$1,204.80 <b>Benefit:</b> 75% = \$	
	bloc dissection of lymph nodes, includ	pen, laparoscopic or robot-assisted approach, with or without en ing associated bladder repair and any associated endoscopic ch item 36533 applies or a service associated with a service to naes.) (Assist.)
<b>Fee</b> 36532	(See para TN.8.154 of explanatory notes to <b>Fee:</b> \$1,729.20 <b>Benefit:</b> 75% = \$	
	bloc dissection of lymph nodes, includ procedures, if complicated by previous	pen, laparoscopic or robot-assisted approach, with or without en ing associated bladder repair and any associated endoscopic s open or laparoscopic surgery on the same kidney or ureter, other e to which item 30390 or 30627 applies (Anaes.) (Assist.)
<b>Fee</b> 36533	(See para TN.8.154 of explanatory notes to <b>Fee:</b> \$2,043.80 <b>Benefit:</b> 75% = \$	
		EXPLORATION OF, with or without drainage of, by open
<b>Fee</b> 36537	exposure, not being a service to which           Fee: \$719.40         Benefit: 75% = \$:	another item in this Sub-group applies (Anaes.) (Assist.)
		r both, extended, for one or more renal stones, including one or licle control with or without freezing, calyorrhaphy or pyeloplasty
Fee 36543	<b>Fee:</b> \$1,343.45 <b>Benefit:</b> 75% = \$	1007.60  85% = \$1258.75
		E LITHOTRIPSY (ESWL) to urinary tract and posttreatment care sultation, unilateral (Anaes.)
<b>Fee</b> 36546		539.55 85% = \$634.70
	Ureterolithotomy, by open, laparoscop	ic or robot-assisted approach (Anaes.) (Assist.)
<b>Fee</b> 36549	<b>Fee:</b> \$866.90 <b>Benefit:</b> 75% = \$6	550.20
20217		n, as an independent procedure (Anaes.) (Assist.)
<b>Fee</b> 36552	<b>Fee:</b> \$771.55 <b>Benefit:</b> 75% = \$:	
	RENAL CYST OR CYSTS, excision	
<b>Fee</b> 36558		507.15 85% = \$591.45
	Renal biopsy, performed under image	
<b>Fee</b> 36561		134.65 85% = \$152.60
20201		the pelvi-ureteric junction) by open, laparoscopic or robot-assisted
<b>F</b> .		retroperitoneal approach (Anaes.) (Assist.)
Fee	<b>Fee:</b> \$962.20 <b>Benefit:</b> 75% = \$	

T8. SUF	GICAL OPERATI	ONS	5. UROLOGICAL
	junction obstruct	kidney that is congenitally abnormal (in addition), or in a solitary kidney, by open, laparoso f a retroperitoneal approach (Anaes.) (Assist.	copic or robot-assisted approach, with or
<b>Fee</b> 36567	(See para TN.8.155 <b>Fee:</b> \$1,057.50	5 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$793.15	
_		plicated by previous surgery on the same kide a, with or without the use of a retroperitoneal	
Fee 36570	Fee: \$1,343.45	<b>Benefit:</b> 75% = \$1007.60	
	DIVIDED URET	ER, repair of (Anaes.) (Assist.)	
Fee 36573	Fee: \$962.20	<b>Benefit:</b> 75% = \$721.65	
		e and exploration of, including repair or nephr approach, other than a service associated with	
	(a) any other prod	cedure performed on the kidney, renal pelvis	or renal pedicle; or
	(b) a service to w	hich item 30390 or 30627 applies (Anaes.) (A	Assist.)
<b>Fee</b> 36576	(See para TN.8.154 <b>Fee:</b> \$1,204.80	of explanatory notes to this Category) Benefit: 75% = \$903.60	
	Ureterectomy, co	mplete or partial:	
	(a) for a tumour v	within the ureter, proven by histopathology at	the time of surgery; or
	(b) for congenital	anomaly;	
	with or without a	ssociated bladder repair (Anaes.) (Assist.)	
Fee 36579	Fee: \$771.55	<b>Benefit:</b> 75% = \$578.70	
	URETER, transp	lantation of, into skin (Anaes.) (Assist.)	
Fee 36585	Fee: \$771.55	<b>Benefit:</b> 75% = \$578.70	
	URETER, reimpl	antation into bladder (Anaes.) (Assist.)	
Fee 36588	Fee: \$962.20	<b>Benefit:</b> 75% = \$721.65	
		antation into bladder with psoas hitch or Boa	ri flap or both (Anaes.) (Assist.)
Fee 36591	Fee: \$1,152.90	<b>Benefit:</b> 75% = \$864.70	
		lantation of, into intestine (Anaes.) (Assist.)	
<b>Fee</b> 36594	Fee: \$962.20	<b>Benefit:</b> 75% = \$721.65	
	URETER, transp	lantation of, into another ureter (Anaes.) (Ass	ist.)
Fee 36597	Fee: \$962.20	<b>Benefit:</b> 75% = \$721.65	
		lantation of, into isolated intestinal segment,	unilateral (Anaes.) (Assist.)
<b>Fee</b> 36600	(See para TN.8.153 <b>Fee:</b> \$1,152.90	B of explanatory notes to this Category) <b>Benefit:</b> 75% = \$864.70 85% = \$1068.20	
<b>Fee</b> 36603	URETERS, trans	plantation of, into isolated intestinal segment	, bilateral (Anaes.) (Assist.)

T8. SUF		ONS 5.	UROLOGICA	
	· •	of explanatory notes to this Category)		
	Fee: \$1,343.45	<b>Benefit:</b> 75% = \$1007.60		
		sage of through percutaneous nephrostomy tube, using interventional ot including imaging (Anaes.)	radiology	
Fee 36604	Fee: \$278.55	<b>Benefit:</b> 75% = \$208.95 85% = \$236.80		
		RINARY RESERVOIR, continent, formation of, including formation of the tation of ureters (1 or both) into reservoir (Anaes.) (Assist.)	of nonreturn	
F <b>ee</b> 36606	<b>Fee:</b> \$2,409.65	<b>Benefit:</b> 75% = \$1807.25		
	Ureteric stent inse	rtion of, with balloon dilatation of:		
	(a) the pelvical	yceal system; or		
	(b) ureter; or			
	(c) the pelvical	yceal system and ureter;		
Ess	through a nephros (Anaes.)	tomy tube using interventional radiology techniques, but not including	g imaging	
<b>Fee</b> 36607	Fee: \$718.70	<b>Benefit:</b> 75% = \$539.05		
	interventional rad	change of, percutaneously through either the ileal conduit or bladder, u iology techniques, but not including imaging, not being a service asso tems 36811 to 36854 apply (Anaes.)		
<b>Fee</b> 36608	<b>Fee:</b> \$278.55	<b>Benefit:</b> 75% = \$208.95		
		conduit, reservoir or ureterostomy, revision of (Anaes.) (Assist.)		
<b>Fee</b> 36609	<b>Fee:</b> \$771.55	<b>Benefit:</b> 75% = \$578.70		
	Intestinal urinary	conduit, incontinent, formation of (including associated small bowel r		
Fee	anastomosis), incl	uding implantation of one or both ureters into reservoir (Anaes.) (Ass	1st.)	
36610	Fee: \$1,846.95	<b>Benefit:</b> 75% = \$1385.25		
	anastomosis), incl	reservoir, continent, formation of (including associated small bowel re uding formation of non-return valves and implantation of one or both led by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.)	ureters into	
Fee 36611	Fee: \$2,913.20	<b>Benefit:</b> 75% = \$2184.90		
		ation of, with or without drainage of, as an independent procedure (Ar	aes.) (Assist.)	
<b>Fee</b> 36612	<b>Fee:</b> \$676.15	<b>Benefit:</b> 75% = \$507.15	, (,	
	Ureterolysis, unilateral, with or without repositioning of the ureter, for obstruction of the ureter, if:			
	(a) the obstruction:			
	(i) is evident either radiologically or by proximal ureteric dilatation at operation; and			
	(ii) is secondary to retroperitoneal fibrosis; and			
<b>Fee</b> 36615	(b) there is biopsy surgery (Anaes.)	proven fibrosis, endometriosis or cancer at the site of the obstruction Assist.)	at time of	

T8. SUF		ONS	5. UROLOGICAL
	· •	of explanatory notes to this Category)	
	Fee: \$771.55	<b>Benefit:</b> 75% = \$578.70	
г	REDUCTION U	RETEROPLASTY (Anaes.) (Assist.)	
Fee 36618	Fee: \$676.15	<b>Benefit:</b> 75% = \$507.15	
	CLOSURE OF C	UTANEOUS URETEROSTOMY (Anaes.) (Assist.)	
Fee 36621	Fee: \$483.35	<b>Benefit:</b> 75% = \$362.55	
	Nephrostomy, pe (Anaes.) (Assist.)	rcutaneous, using interventional radiology techniques,	but not including imaging
Fee 36624	<b>Fee:</b> \$580.75	<b>Benefit:</b> 75% = \$435.60 85% = \$496.05	
	Nephroscopy, pe	rcutaneous, with or without any one or more of; stone e ce to which item 36639 or 36645 applies (Anaes.)	extraction, biopsy or diathermy,
Fee 36627	Fee: \$719.40	<b>Benefit:</b> 75% = \$539.55	
	and including and	rcutaneous, with incision of any one or more of; renal p regrade insertion of ureteric stent, not being a service as 99 or 36645 applies (Anaes.) (Assist.)	
Fee 36633	Fee: \$771.55	<b>Benefit:</b> 75% = \$578.70 85% = \$686.85	
	and including and	rcutaneous, with incision of any one or more of; renal p egrade insertion of ureteric stent, being a service assoc 9 or 36645 applies (Anaes.) (Assist.)	
Fee 36636	Fee: \$416.10	<b>Benefit:</b> 75% = \$312.10	
-		rcutaneous, with destruction and extraction of one or tw shock waves or lasers, other than a service to which ite	
Fee 36639	Fee: \$866.90	<b>Benefit:</b> 75% = \$650.20	
		7, percutaneous, with removal or destruction of a stone 3 or more stones (Anaes.) (Assist.)	greater than 3 cm in any
Fee 36645	Fee: \$1,109.50	<b>Benefit:</b> 75% = \$832.15	
	Nephrostomy dra imaging (Anaes.)	inage tube, exchange of, using interventional radiology (Assist.)	/ techniques, but not including
Fee 36649	Fee: \$278.55	<b>Benefit:</b> 75% = \$208.95 85% = \$236.80	
	Nephrostomy tube, removal of, using interventional radiology techniques, but not including imaging, if the ureter has been stented with a double J ureteric stent and that stent is left in place (Anaes.)		
Fee 36650	Fee: \$155.80	<b>Benefit:</b> 75% = \$116.85	
	PYELOSCOPY, ureteric meatotor	retrograde, of one collecting system, with or without an ny, ureteric dilatation, not being a service associated with 36824 applies (Anaes.) (Assist.)	
Fee 36652	Fee: \$676.15	<b>Benefit:</b> 75% = \$507.15	
<b>Fee</b> 36654	PYELOSCOPY, 1 or more of extr	retrograde, of one collecting system, being a service to action of stone from the renal pelvis or calyces, or biop not being a service associated with a service to which	sy or diathermy of the renal

T8. SUF	RGICAL OPERATIONS 5. UROLOGIC	;AL
	procedure performed in the same collecting system (Anaes.) (Assist.)	
	<b>Fee:</b> \$866.90 <b>Benefit:</b> 75% = \$650.20	
	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, pl extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Anaes.) (Assist.)	
Fee 36656	<b>Fee:</b> \$1,109.50 <b>Benefit:</b> 75% = \$832.15	
	OPERATIONS ON BLADDER	
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, includin 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, 3723 or 37233 applies.	
	(Anaes.)	
Fee 36504	(See para TN.8.2 of explanatory notes to this Category)Fee: $\$306.80$ Benefit: $75\% = \$230.10$ $85\% = \$260.80$	
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, includin catheterisation, with urethroscopy with or without urethral dilatation, not being a service associated w any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies.	
	(Anaes.)	
<b>Fee</b> 36505	(See para TN.8.2 of explanatory notes to this Category)           Fee: \$241.10         Benefit: 75% = \$180.85         85% = \$204.95	
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, includin catheterisation, with resection, diathermy or visual laser destruction of bladder tumour or other lesion the bladder, not being a service to which item 36840 or 36845 applies.	
	(Anaes.)	
<b>Fee</b> 36507	(See para TN.8.2 of explanatory notes to this Category)Fee: $$403.90$ Benefit: $75\% = $302.95$ $85\% = $343.35$	
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, includin catheterisation, with diathermy, resection or visual laser destruction of multiple tumours in more than quadrants of the bladder or solitary tumour greater than 2cm in diameter, not being a service to which item 36845 applies.	2
	(Anaes.)	
<b>Fee</b> 36508	(See para TN.8.2 of explanatory notes to this Category)           Fee: \$787.05         Benefit: 75% = \$590.30         85% = \$702.35	
	Both:	
Fee 36663	(a) percutaneous placement of sacral nerve lead or leads using fluoroscopic guidance, or open placem	ent

GICAL OPERATIONS 5. UROLOGICAL
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.)
Fee: \$687.75 Benefit: 75% = \$515.85 85% = \$603.05
Both:
(a) percutaneous repositioning of sacral nerve lead or leads using fluoroscopic guidance, or open repositioning of sacral nerve lead or leads; and
(b) intra-operative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of:
(i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or
(ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment
—other than a service to which item 36663 applies (Anaes.)
<b>Fee:</b> \$617.60 <b>Benefit:</b> 75% = \$463.20 85% = \$532.90
Sacral nerve electrode or electrodes, management and adjustment of the pulse generator by a medical practitioner, to manage detrusor overactivity or non obstructive urinary retention - each day
Fee: \$130.45         Benefit: 75% = \$97.85         85% = \$110.90
Pulse generator, subcutaneous placement of, and placement and connection of extension wire or wires to sacral nerve electrode or electrodes, for the management of:
(a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or
(b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.)
<b>Fee:</b> \$347.55 <b>Benefit:</b> 75% = \$260.70 85% = \$295.45
Sacral nerve lead or leads, removal of, if the lead was inserted to manage:
(a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or
(b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment
(Anaes.)
<b>Fee:</b> \$162.65 <b>Benefit:</b> 75% = \$122.00 85% = \$138.30

T8. SUF	RGICAL OPERATIONS 5. URC	LOGICAL
	Pulse generator, removal of, if the pulse generator was inserted to manage:	
	(a) detrusor over-activity that has been refractory to at least 12 months conservative non-surg treatment; or	ical
	(b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment	ve
<b>Fee</b> 36668	(Anaes.) <b>Fee:</b> \$162.65 <b>Benefit:</b> 75% = \$122.00 85% = \$138.30	
30008	Percutaneous tibial nerve stimulation, initial treatment protocol, for the treatment of overactive $r_{1}$	e bladder
	by a specialist urologist, gynaecologist or urogynaecologist, if:	e bladdel,
	(a) the patient has been diagnosed with idiopathic overactive bladder; and	
	(b) the patient has been refractory to, is contraindicated or otherwise not suitable for conservative treatments (including anti-cholinergic agents); and	ıtive
	(c) the patient is contraindicated or otherwise not a suitable candidate for botulinum toxin typ therapy; and	e A
	(d) the patient is contraindicated or otherwise not a suitable candidate for sacral nerve stimula	tion; and
	(e) the patient is willing and able to comply with the treatment protocol; and	
	(f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month period; and	
	(g) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 mi	nutes.
	For each patient—applicable only once, unless the patient achieves at least a 50% reduction in overactive bladder symptoms from baseline at any time during the 3 month treatment period.	n
	Not applicable for a service associated with a service to which item 36672 or 36673 applies	
<b>Fee</b> 36671	<b>Fee:</b> \$208.10 <b>Benefit:</b> 75% = \$156.10 85% = \$176.90	
	Percutaneous tibial nerve stimulation, tapering treatment protocol, for the treatment of overac bladder, including any associated consultation at the time the percutaneous tibial nerve stimul treatment is administered, if:	
	(a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protoco achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time of treatment period for the initial treatment protocol; and	
	(b) the tapering treatment protocol comprises no more than 5 sessions, delivered over a 3 mor and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of treatment; and	
	(c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 mi	nutes.
<b>Fee</b> 36672	Not applicable for a service associated with a service to which item 36671 or 36673 applies	

T8. SUF	RGICAL OPERAT	TIONS	5. UROLOGICAL
	_	-	
	<b>Fee:</b> \$208.10	<b>Benefit:</b> $75\% = \$156.10$ $85\% = \$176.90$	a treatment of averative
		bial nerve stimulation, maintenance treatment protocol, for the ng any associated consultation at the time the percutaneous ti ninistered, if:	
	tapering treatme	esponded to the percutaneous tibial nerve stimulation initial tr ent protocol, and has achieved at least a 50% reduction in ove any time during the treatment period for the initial treatment	ractive bladder symptoms
		ance treatment protocol comprises no more than 12 sessions, of interval between sessions is adjusted with the aim of sustaining	
	(c) each session	lasts for a minimum of 45 minutes, of which neurostimulation	on lasts for 30 minutes.
	Not applicable fo	for service associated with a service to which item 36671 or 3	66672 applies
Fee			
36673	Fee: \$208.10	<b>Benefit:</b> 75% = \$156.10 85% = \$176.90	
Fee	BLADDER, cath	heterisation of, where no other procedure is performed (Anae	es.)
36800	Fee: \$28.70	<b>Benefit:</b> 75% = \$21.55 85% = \$24.40	
	ureteric dilatatio	f one ureter, with or without any one or more of; cystoscopy, on, not being a service associated with a service to which item 36809, 36812, 36824 or 36848 applies (Anaes.) (Assist.)	
<b>Fee</b> 36803	(See para TN.8.51 <b>Fee:</b> \$485.25	l of explanatory notes to this Category) <b>Benefit:</b> $75\% = $363.95$ $85\% = $412.50$	
	Ureteroscopy, of	f one ureter:	
	(a) with or with	out one or more of the following:	
	(i) cystosco	opy;	
	(ii) endosc	copic incision of pelviureteric junction or ureteric stricture;	
	(iii) ureteri	ic meatotomy;	
	(iv) ureteri	ic dilatation; and	
	(b) with either or	or both of the following:	
	(i) extraction	ion of stone from the ureter;	
	(ii) biopsy	or diathermy of the ureter;	
	other than:		
Eac	(c) a service asso	ociated with a service to which item 36803 or 36812 applies;	or
Fee 36806	(d) a service asso	ociated with a service, performed on the same ureter, to whic	h item 36809, 36824 or

T8. SUF	RGICAL OPERATIONS 5. UROLOGICA	۱L	
	36848 applies (Anaes.) (Assist.)		
	<b>Fee:</b> \$676.15 <b>Benefit:</b> 75% = \$507.15		
Fee	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 servi 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.)		
ree 36809	<b>Fee:</b> \$866.90 <b>Benefit:</b> 75% = \$650.20		
Ess	Cystoscopy, with insertion of one or more urethral or prostatic prostheses, other than a service associat with a service to which item 37203, 37207 or 37230 applies (Anaes.)	ed	
<b>Fee</b> 36811	<b>Fee:</b> \$336.50 <b>Benefit:</b> 75% = \$252.40 85% = \$286.05		
Fee	Either or both of cystoscopy and urethroscopy, with or without urethral dilatation, other than a service associated with any other urological endoscopic procedure on the lower urinary tract (Anaes.)		
36812	Fee: \$173.45         Benefit: 75% = \$130.10         85% = \$147.45		
	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (Anaes.)		
<b>Fee</b> 36815	(See para TN.8.9 of explanatory notes to this Category) <b>Fee:</b> \$247.55 <b>Benefit:</b> 75% = \$185.70 85% = \$210.45		
	Cystoscopy, with ureteric catheterisation, unilateral or bilateral, guided by fluoroscopic imaging of the upper urinary tract, other than a service associated with a service to which item 36824 or 36830 applies (Anaes.)		
Fee 36818	<b>Fee:</b> \$287.80 <b>Benefit:</b> 75% = \$215.85 85% = \$244.65		
Ess	Cystoscopy with one or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureteric or renal pelvis, unilateral (Anaes.) (Assist.)	r	
Fee 36821	<b>Fee:</b> \$336.30 <b>Benefit:</b> 75% = \$252.25 85% = \$285.90		
	Cystoscopy, with ureteric catheterisation, unilateral:		
	(a) guided by fluoroscopic imaging of the upper urinary tract; and		
	(b) including one or more of ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or or renal pelvis;	of	
_	other than a service associated with a service to which item 36818, 36821 or 36830 applies (Anaes.) (Assist.)		
Fee 36822	<b>Fee:</b> \$480.25 <b>Benefit:</b> 75% = \$360.20 85% = \$408.25		
	Cystoscopy, with removal of ureteric stent and ureteric catheterisation, unilateral:		
	(a) guided by fluoroscopic imaging of the upper urinary tract; and		
	(b) including either or both of the following:		
	(i) ureteric dilatation; or		
Fee 36823	(ii) insertion of ureteric stent of ureter or of renal pelvis;		

T8. SUR	GICAL OPERATI	ONS		5. UROLOGICAL
	other than a servi (Anaes.) (Assist.)		e to which item 36818, 36821, 36830 o	r 36833 applies
	Fee: \$552.20	<b>Benefit:</b> 75% = \$414.15	85% = \$469.40	
	• • • •	ureteric catheterisation, un item 36818 applies (Anaes.	nilateral or bilateral, other than a service	e associated with a
Fee 36824	Fee: \$221.80	<b>Benefit:</b> 75% = \$166.35	85% = \$188.55	
	Cystoscopy, with		of the bladder, other than a service ass	ociated with a service
Fee 36827	Fee: \$239.20	<b>Benefit:</b> 75% = \$179.40	85% = \$203.35	
	CYSTOSCOPY,	with ureteric meatotomy (A	Anaes.)	
Fee 36830	Fee: \$211.50	<b>Benefit:</b> 75% = \$158.65		
			or other foreign body in the lower urina	ry tract, unilateral
Fee 36833	Fee: \$287.80	<b>Benefit:</b> 75% = \$215.85	85% = \$244.65	
		1.	t being a service associated with a servi , 37203, 37206, 37215, 37230 or 37233	
<b>Fee</b> 36836	(See para TN.8.2 or <b>Fee:</b> \$239.20	f explanatory notes to this Cate Benefit: 75% = \$179.40		
	Cystoscopy, with bladder, for:	diathermy, resection or vis	sual laser destruction of bladder tumour	r or other lesion of the
	(a) a tumour or le	sion in only one quadrant o	of the bladder; or	
	(b) a solitary tum	our of not more than 2 cm	in diameter;	
	other than a servi	ce associated with a service	e to which item 36845 applies (Anaes.)	
Fee 36840	<b>Fee:</b> \$336.30	<b>Benefit:</b> 75% = \$252.25	85% = \$285.90	
	bladder, other that	lavage of blood clots from	a bladder, including any associated caut a service to which any of items 36812,	
<b>Fee</b> 36842	(See para TN.8.158 <b>Fee:</b> \$338.35	3 of explanatory notes to this C Benefit: 75% = \$253.80		
	Cystoscopy, with	diathermy, resection or vis	sual laser destruction of:	
	(a) multiple tumours in 2 or more quadrants of the bladder; or			
	(b) a solitary bladder tumour of more than 2 cm in diameter (Anaes.)			
Fee 36845	<b>Fee:</b> \$719.40	<b>Benefit:</b> 75% = \$539.55		
50075		with resection of ureteroce		
<b>Fee</b> 36848	<b>Fee:</b> \$239.20	<b>Benefit:</b> 75% = \$179.40		
<b>Fee</b> 36851			l, other than a service associated with a	service to which item

T8. SUF	GICAL OPERATIONS		5. UROLOGICAL
	18375 or 18379 applies ()	H) (Anaes.)	
	Fee: \$239.20 Ben	<b>efit:</b> 75% = \$179.40	
	CYSTOSCOPY, with end (Anaes.)	doscopic incision or resection of external sphincte	er, bladder neck or both
Fee 36854	<b>Fee:</b> \$485.25 <b>Ben</b>	<b>uefit:</b> 75% = \$363.95	
<b>Fee</b> 36860		NATION of intestinal conduit or reservoir (Anaes <b>refit:</b> 75% = \$130.10 85% = \$147.45	)
30800	Litholapaxy, with or with		
<b>Fee</b> 36863		efit: 75% = \$363.95	
	BLADDER, partial excisi	ion of (Anaes.) (Assist.)	
<b>Fee</b> 37000	·	anatory notes to this Category) nefit: 75% = \$578.70	
	BLADDER, repair of rup	oture (Anaes.) (Assist.)	
<b>Fee</b> 37004	<b>Fee:</b> \$676.15 <b>Ben</b>	<b>efit:</b> 75% = \$507.15	
		otomy, suprapubic, other than:	
	(a) a service to which iter	m 37011 applies; or	
	(b) a service associated w	with a service to which item 37245 applies; or	
_	(c) another open bladder	procedure (Anaes.) (Assist.)	
Fee 37008	Fee: \$433.30 Ben	<b>efit:</b> 75% = \$325.00 85% = \$368.35	
	Suprapubic stab cystotom (Anaes.)	ny, other than a service associated with a service t	o which item 36827 applies
<b>Fee</b> 37011		anatory notes to this Category) aefit: 75% = \$72.85 85% = \$82.55	
	BLADDER, total excision	n of (Anaes.) (Assist.)	
<b>Fee</b> 37014		natory notes to this Category) nefit: 75% = \$832.15	
	Bladder, total excision of, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis (Anaes.) (Assist.)		assisted surgery, or radiation
Fee 37015	Fee: \$1,331.40 Ben	<b>nefit:</b> 75% = \$998.55	
	Cystectomy, including prostatectomy and pelvic lymph node dissection, other than a service associated with a service to which items 37000, 37014, 37015, 37209, 35551 or 36502 applies (Anaes.) (Assist.)		
<b>Fee</b> 37016	Fee: \$2,076.05 Ben	<b>nefit:</b> 75% = \$1557.05	
	laparoscopic or robot-ass	rostatectomy and pelvic lymph node dissection, for isted surgery, or radiation therapy or chemotherap service to which items 37000, 37014, 37015, 370	by to the pelvis, other than a
<b>Fee</b> 37018	<b>Fee:</b> \$3,114.15 <b>Ben</b>	<b>uefit:</b> 75% = \$2335.65	

T8. SUF	GICAL OPERAT	IONS	5. UROLOGICAL
F		uding anterior exenteration and pelvic lymph no service to which any of items 37000, 37014, 3 Assist.)	
Fee 37019	Fee: \$2,073.70	<b>Benefit:</b> 75% = \$1555.30	
Fee	BLADDER DIV	ERTICULUM, excision or obliteration of (Ana	es.) (Assist.)
37020	Fee: \$771.55	<b>Benefit:</b> 75% = \$578.70	
Fee	laparoscopic or r	uding anterior exenteration and pelvic lymph no obot-assisted surgery, radiation therapy or chen d with a service to which any of items 37000, 3 Anaes.) (Assist.)	notherapy to the pelvis, other than a
37021	Fee: \$3,110.55	<b>Benefit:</b> 75% = \$2332.95	
Fee	VESICAL FIST	ULA, cutaneous, operation for (Anaes.)	
37023	Fee: \$433.30	<b>Benefit:</b> 75% = \$325.00	
	CUTANEOUS V	/ESICOSTOMY, establishment of (Anaes.) (As	ssist.)
Fee 37026	<b>Fee:</b> \$433.30	<b>Benefit:</b> 75% = \$325.00	
37020		AL FISTULA, closure of, by abdominal approx	ach (Anaes.) (Assist.)
Fee 37029	<b>Fee:</b> \$962.20	<b>Benefit:</b> 75% = \$721.65	() ()
	VESICOINTEST	FINAL FISTULA, closure of, excluding bowel	resection (Anaes.) (Assist.)
Fee 37038	Fee: \$719.75	<b>Benefit:</b> 75% = \$539.85	
57030		continence, sling procedure for, using a non-aut	tologous biological sling (Anaes.)
Fee 37039	<b>Fee:</b> \$701.85	<b>Benefit:</b> 75% = \$526.40	
P		continence, sling procedure for, using a non-adj ice associated with a service to which item 3040	
Fee 37040	Fee: \$948.25	<b>Benefit:</b> 75% = \$711.20	
	BLADDER ASP	IRATION by needle	
Fee 37041	Fee: \$48.50	<b>Benefit:</b> 75% = \$36.40 85% = \$41.25	
	Bladder stress incontinence, sling procedure for, using autologous fascial sling, including harvesting of sling, other than a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.)		
Fee 37042	Fee: \$948.25	<b>Benefit:</b> 75% = \$711.20	
	Bladder stress incontinence, Stamey or similar type needle colposuspension, other than a service		
Fee	associated with a	service to which item 30405 or 35599 applies	(Anaes.) (Assist.)
37043	Fee: \$701.85	<b>Benefit:</b> 75% = \$526.40	
		continence, suprapubic procedure for, eg Burch a service to which item 30405 or 35599 applies	
Fee 37044	Fee: \$719.75	<b>Benefit:</b> 75% = \$539.85	
Fee	CONTINENT C	ATHETERISATION BLADDER STOMAS (eg	g. Mitrofanoff), formation of (Anaes.)

T8. SUF	GICAL OPERATIONS		5. UROLOGICAL
37045	(Assist.)		
	Fee: \$1,486.60 Be	e <b>nefit:</b> 75% = \$1114.95	
	BLADDER ENLARGE	EMENT using intestine (Anaes.) (A	ssist.)
Fee 37047	Fee: \$1,733.55 Be	enefit: 75% = \$1300.20	
	Bladder neck closure for	or the management of urinary incom	tinence (Anaes.) (Assist.)
Fee 37048	Fee: \$962.20 Be	enefit: 75% = \$721.65	
	BLADDER EXSTROP	HY CLOSURE, not involving sphi	ncter reconstruction (Anaes.) (Assist.)
Fee 37050	Fee: \$771.55 Be	enefit: 75% = \$578.70	
	BLADDER TRANSEC	TION AND RE-ANASTOMOSIS	TO TRIGONE (Anaes.) (Assist.)
Fee 37053	Fee: \$891.40 Be	e <b>nefit:</b> 75% = \$668.55	
		OPERATIONS ON PR	OSTATE
	Prostatectomy, by open	, laparoscopic or robot-assisted app	roach (Anaes.) (Assist.)
<b>Fee</b> 37200		planatory notes to this Category) enefit: 75% = \$793.15	
	medically fit for transur punch) and including se or 37324 applies (Anae	rethral resection of the prostate (tha ervices to which item 36854, 37203 s.)	ower urinary tract symptoms who are not t is, prostatectomy using diathermy or cold , 37206, 37207, 37208, 37245, 37303, 37321
Fee 37201		anatory notes to this Category) enefit: 75% = \$646.85	
	without urethroscopy, in medically fit for transum punch) and including se	n patients with moderate to severe 1 rethral resection of the prostate (tha ervices to which item 36854, 37245 e procedure described by item 3720	of, with or without cystoscopy and with or ower urinary tract symptoms who are not t is prostatectomy using diathermy or cold , 37303, 37321 or 37324 applies, continuation 11, 37203 or 37207 which had to be
<b>Fee</b> 37202		anatory notes to this Category) e <b>nefit:</b> 75% = \$324.70 85% = \$368.0	0
		ding services to which item 36854,	or without cystoscopy and with or without 37201, 37202, 37207, 37208, 37245, 37303,
<b>Fee</b> 37203		blanatory notes to this Category) enefit: 75% = \$813.30	
	Prostatectomy, endosco	ppic, using diathermy or other ablati	ve techniques:
	(a) with or without cyst	oscopy and with or without urethro	scopy; and
	(b) including services to	o which one or more of items 36854	I, 37303, 37321 and 37324 apply;
<b>Fee</b> 37206	continuation, within 10 medical reasons (Anaes	• • •	tic hyperplasia that had to be discontinued for

T8. SUF	RGICAL OPERATIONS	5. UROLOGICAL	
	(See para TN.8.158 of explanatory notes to this Category) <b>Fee:</b> \$580.75 <b>Benefit:</b> 75% = \$435.60		
	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or withow with or without urethroscopy, and including services to which items 36854, 37201, 3 37206, 37245, 37303, 37321 or 37324 applies (Anaes.)		
Fee 37207	<b>Fee:</b> \$1,084.35 <b>Benefit:</b> 75% = \$813.30		
	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or withow with or without urethroscopy, and including services to which item 36854, 37303, 37 applies, continuation of, within 10 days of the procedure described by items 37201, 3 37245 which had to be discontinued for medical reasons (Anaes.)	'321 or 37324	
Fee 37208	<b>Fee:</b> \$580.75 <b>Benefit:</b> 75% = \$435.60		
F	PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilate of, not being a service associated with a service to which item number 37210 or 3721 (Assist.)		
Fee 37209	<b>Fee:</b> \$1,343.45 <b>Benefit:</b> 75% = \$1007.60		
	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves are (where clinically indicated) with or without bladder neck reconstruction, other than a with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.)	service associated	
<b>Fee</b> 37210	(See para TN.8.161 of explanatory notes to this Category) <b>Fee:</b> \$1,658.00 <b>Benefit:</b> 75% = \$1243.50		
	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves are (where clinically indicated):	und the prostate	
	(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.)		
<b>Fee</b> 37211	(See para TN.8.161 of explanatory notes to this Category) <b>Fee:</b> \$2,013.60 <b>Benefit:</b> 75% = \$1510.20		
	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves are (where clinically indicated):	und the prostate	
	(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, 36 applies (Anaes.) (Assist.)	502 or 37375	
<b>Fee</b> 37213	(See para TN.8.161 of explanatory notes to this Category) <b>Fee:</b> \$2,486.85 <b>Benefit:</b> 75% = \$1865.15		
Fee	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves arou	und the prostate	

T8. SUF	GICAL OPERATIONS 5. UROLOGICAL
37214	(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.)
	(See para TN.8.161 of explanatory notes to this Category) <b>Fee:</b> $$3,020.65$ <b>Benefit:</b> $75\% = $2265.50$
Fee	Prostate, biopsy of, endoscopic, with or without cystoscopy (Anaes.)
37215	<b>Fee:</b> \$433.30 <b>Benefit:</b> 75% = \$325.00 85% = \$368.35
	Prostate or prostatic bed, needle biopsy of, by the transrectal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55603 applies (Anaes.)
<b>Fee</b> 37216	(See para TN.8.160 of explanatory notes to this Category) <b>Fee:</b> \$146.15 <b>Benefit:</b> 75% = \$109.65 85% = \$124.25
	Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed, under ultrasound guidance, being an item associated with a service to which item 55603 applies (Anaes.)
<b>Fee</b> 37217	(See para TN.8.54 of explanatory notes to this Category)Fee: $$143.90$ Benefit: $75\% = $107.95$ $85\% = $122.35$
	Prostate, injection into, one or more, excluding insertion of fiduciary markers (Anaes.)
<b>Fee</b> 37218	(See para TN.8.54 of explanatory notes to this Category)Fee: $$143.90$ Benefit: $75\% = $107.95$ $85\% = $122.35$
	Prostate or prostatic bed, needle biopsy of, by the transperineal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.)
<b>Fee</b> 37219	(See para TN.8.160 of explanatory notes to this Category) <b>Fee:</b> $$350.75$ <b>Benefit:</b> $75\% = $263.10$ $85\% = $298.15$
	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 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 a urologist at an approved site in association with a radiation oncologist; and
<b>Fee</b> 37220	(c) being a service associated with:

T8. SUR	RGICAL OPERATIONS	5. UROLOGICAL	
	(i) services to which items 15338 and 55603 apply; and		
	(ii) a service to which item 60506 or 60509 applies (Anaes.)		
	(See para TN.8.55 of explanatory notes to this Category) <b>Fee:</b> \$1,086.50 <b>Benefit:</b> 75% = \$814.90		
	Prostatic abscess, endoscopic drainage of (Anaes.)		
Fee 37221	<b>Fee:</b> \$485.25 <b>Benefit:</b> 75% = \$363.95		
	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.)		
Fee 37223	<b>Fee:</b> \$214.60 <b>Benefit:</b> 75% = \$160.95		
T	Prostate, diathermy or cauterisation, other than a service associated with a service 37202, 37203, 37206, 37207, 37208 or 37215 applies (Anaes.)	vice to which item 37201,	
Fee 37224	<b>Fee:</b> \$336.30 <b>Benefit:</b> 75% = \$252.25 85% = \$285.90		
	PROSTATE, transperineal insertion of catheters into, for high dose rate brach guidance including any associated cystoscopy. The procedure must be perform association with a radiation oncologist, and be associated with a service to wh applies. (Anaes.)	ned at an approved site in	
<b>Fee</b> 37227	(See para TN.8.56 of explanatory notes to this Category) <b>Fee:</b> \$588.75 <b>Benefit:</b> 75% = \$441.60 85% = \$504.05		
	Prostate, ablation by electrocautery or high-energy transurethral microwave th without cystoscopy and with or without urethroscopy (Anaes.)	ermotherapy, with or	
<b>Fee</b> 37230	(See para TN.8.163 of explanatory notes to this Category) <b>Fee:</b> \$1,084.35 <b>Benefit:</b> 75% = \$813.30 85% = \$999.65		
	Prostate, ablation by electrocautery or high-energy transurethral microwave th without cystoscopy and with or without urethroscopy, continuation, within 10 procedure of the prostate that had to be discontinued for medical reasons (Ana	days, of a urological	
<b>Fee</b> 37233	(See para TN.8.163 of explanatory notes to this Category) <b>Fee:</b> \$580.75 <b>Benefit:</b> 75% = \$435.60 85% = \$496.05		
	Prostate, endoscopic enucleation of, for the treatment of benign prostatic hype	rplasia:	
	(a) with morcellation, including mechanical morcellation or by an endoscopic	technique; and	
	(b) with or without cystoscopy; and		
	(c) with or without urethroscopy; and		
_	other than a service associated with a service to which item 36827, 36854, 37008, 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.)		
Fee 37245	<b>Fee:</b> \$1,313.30 <b>Benefit:</b> 75% = \$985.00		
	OPERATIONS ON URETHRA, PENIS OR SCROTU	M	
	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.)		
Fee 37300	<b>Fee:</b> \$48.50 <b>Benefit:</b> 75% = \$36.40 85% = \$41.25		
<b>Fee</b> 37303	URETHRAL STRICTURE, dilatation of (Anaes.)		

GICAL OPERAT	IONS 5. UROLOGICAL	
Fee: \$77.10	<b>Benefit:</b> 75% = \$57.85 85% = \$65.55	
URETHRA, repair of rupture of distal section (Anaes.) (Assist.)		
Fee: \$676.15	<b>Benefit:</b> 75% = \$507.15	
URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.)		
Fee: \$962.20	<b>Benefit:</b> 75% = \$721.65	
	ith or without cystoscopy, with one or more of biopsy, diathermy, visual laser ethral calculi or removal of foreign body or calculi (Anaes.)	
Fee: \$287.80	<b>Benefit:</b> 75% = \$215.85 85% = \$244.65	
URETHRAL M	EATOTOMY, EXTERNAL (Anaes.)	
Fee: \$97.10	<b>Benefit:</b> 75% = \$72.85 85% = \$82.55	
Urethrotomy or	urethrostomy, internal or external (Anaes.) (Assist.)	
<b>Fee:</b> \$239.20	<b>Benefit:</b> 75% = \$179.40	
	IY, optical, for urethral stricture (Anaes.) (Assist.)	
<b>Fee:</b> \$336.30	<b>Benefit:</b> 75% = \$252.25	
URETHRECTO	MY, partial or complete, for removal of tumour (Anaes.) (Assist.)	
Fee: \$676.15	<b>Benefit:</b> 75% = \$507.15	
	GINAL FISTULA, closure of (Anaes.) (Assist.)	
	<b>Benefit:</b> 75% = \$435.60	
URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.)		
Fee: \$771.55	<b>Benefit:</b> 75% = \$578.70	
Urethral synthetic male sling system, division or removal of, for urethral obstruction, sling erosion, pa or infection, following previous surgery for urinary incontinence, other than a service associated with a service to which item 37340 or 37341 applies (Anaes.) (Assist.)		
Fee: \$948.25	<b>Benefit:</b> 75% = \$711.20	
Periurethral or transurethral injection of urethral bulking agents for the treatment of urinary incontinence, including cystoscopy and urethroscopy, other than a service associated with a service to which item 18375 or 18379 applies (Anaes.)		
Fee: \$249.60	<b>Benefit:</b> 75% = \$187.20 85% = \$212.20	
Urethral synthetic sling, division or removal of, for urethral obstruction, sling erosion, pain or infectio following previous surgery for urinary incontinence, vaginal approach, other than a service associated with a service to which item 37341 or 37344 applies (Anaes.) (Assist.)		
Fee: \$948.25	<b>Benefit:</b> 75% = \$711.20	
Urethral sling, division or removal of, for urethral obstruction, sling erosion, pain or infection f previous surgery for urinary incontinence, suprapubic, combined suprapubic and vaginal or con suprapubic and perineal approach, other than a service associated with a service to which item 37344 applies (Anaes.) (Assist.)		
57544 applies (A		
	URETHRA, repairFee: \$676.15URETHRA, repairFee: \$962.20Urethroscopy, wdestruction of urFee: \$287.80URETHRAL MIFee: \$287.80URETHRAL MIFee: \$97.10Urethrotomy or urFee: \$239.20URETHROTOMFee: \$336.30URETHROTOMFee: \$676.15URETHROVACFee: \$676.15URETHRORECFee: \$580.75URETHRORECFee: \$771.55Urethral syntheti or infection, followService to whichFee: \$948.25Periurethral or trincontinence, ind which item 1837Fee: \$249.60Urethral syntheti following previowWith a service toFee: \$948.25Urethral sling, di previous surgery	

T8. SUF		DNS 5. UR	ROLOGICAL
	URETHROPLAST	ΓY single stage operation (Anaes.) (Assist.)	
Fee 37342	Fee: \$866.90	<b>Benefit:</b> 75% = \$650.20	
	below the symphys	<b>FY</b> , single stage operation, transpubic approach via separate incisions abors sis pubis, excluding laparotomy, symphysectomy and suprapubic cystotom of the urethra around the crura (Anaes.) (Assist.)	
Fee	<b>Foot</b> \$1 447 50	<b>Benefit:</b> 75% = \$1085.65	
37343	Fee: \$1,447.50	benefit: $75\% = $1083.65$ is fascial sling (or other biological sling), division or removal of, for ureth	hral
-	obstruction, sling e	erosion, pain or infection following previous surgery for urinary incontine an a service to which 37340 or 37341 applies (Anaes.) (Assist.)	
Fee 37344	Fee: \$948.25	<b>Benefit:</b> 75% = \$711.20	
	URETHROPLAST	ΓY 2 stage operation first stage (Anaes.) (Assist.)	
Fee 37345	Fee: \$719.40	<b>Benefit:</b> 75% = \$539.55	
37343		TY 2 stage operation second stage (Anaes.) (Assist.)	
Fee			
37348	Fee: \$719.40	<b>Benefit:</b> 75% = \$539.55	
Fee	URETHROPLAST	$\Gamma$ Y, not being a service to which another item in this Group applies (Anae	es.) (Assist.)
37351	Fee: \$287.80	<b>Benefit:</b> 75% = \$215.85	
	HYPOSPADIAS,	meatotomy and hemicircumcision (Anaes.) (Assist.)	
Fee 37354	Fee: \$336.30	<b>Benefit:</b> 75% = \$252.25	
	URETHRA, excision of prolapse of (Anaes.)		
Fee		• • • · · ·	
37369	Fee: \$194.20	Benefit: $75\% = \$145.65$	
Fee	Urethral diverticulum, excision of (Anaes.) (Assist.)		
37372	Fee: \$962.20         Benefit: 75% = \$721.65		
		INCTER, reconstruction by bladder tubularisation technique or similar pr	rocedure
Fee	(Anaes.) (Assist.)		
37375	Fee: \$1,204.80	<b>Benefit:</b> 75% = \$903.60	
Fee	ARTIFICIAL URI	INARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assi	ist.)
37381	Fee: \$771.55	<b>Benefit:</b> 75% = \$578.70	
	ARTIFICIAL URI	NARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (A	ssist.)
Fee 37384	Fee: \$1,204.80	<b>Benefit:</b> 75% = \$903.60	
		INARY SPHINCTER, insertion of pressure regulating balloon and pump	(Anaes.)
Fee 37387	Fee: \$336.30	<b>Benefit:</b> 75% = \$252.25	
		phincter, sterile, percutaneous adjustment of filling volume	
<b>Fee</b> 37388	Fee: \$101.90	<b>Benefit:</b> 75% = \$76.45 85% = \$86.65	

T8. SUF	RGICAL OPERAT	IONS 5. UROLOGICAL		
F	ARTIFICIAL U. (Assist.)	RINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.)		
<b>Fee</b> 37390	Fee: \$962.20	<b>Benefit:</b> 75% = \$721.65		
	PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.)			
Fee 37393	Fee: \$239.20	<b>Benefit:</b> 75% = \$179.40 85% = \$203.35		
57575		nt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.)		
<b>Fee</b> 37396	Fee: \$771.55	<b>Benefit:</b> 75% = \$578.70		
	PENIS, partial a	mputation of (Anaes.) (Assist.)		
<b>Fee</b> 37402	Fee: \$485.25	<b>Benefit:</b> 75% = \$363.95		
	PENIS, complete	e or radical amputation of (Anaes.) (Assist.)		
<b>Fee</b> 37405	Fee: \$962.20	<b>Benefit:</b> 75% = \$721.65		
	PENIS, repair of	Elaceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.)		
<b>Fee</b> 37408	Fee: \$485.25	<b>Benefit:</b> 75% = \$363.95		
		avulsion (Anaes.) (Assist.)		
<b>Fee</b> 37411	Fee: \$962.20	<b>Benefit:</b> 75% = \$721.65 85% = \$877.50		
Б	Penis, injection of, for the investigation and treatment of erectile dysfunction. Applicable not more than twice in a 36-month period			
<b>Fee</b> 37415	Fee: \$48.50	<b>Benefit:</b> 75% = \$36.40 85% = \$41.25		
Fee	Penis, correction	of chordee by plication techniques including Nesbit's corporoplasty (Anaes.) (Assist.)		
37417	Fee: \$580.75	<b>Benefit:</b> 75% = \$435.60		
		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.)		
<b>Fee</b> 37418	Fee: \$771.55	<b>Benefit:</b> 75% = \$578.70 85% = \$686.85		
		ng by translocation of corpora, in conjunction with partial penectomy or penile dary repair, either as primary or secondary procedures (Anaes.) (Assist.)		
<b>Fee</b> 37423	(See para TN.8.164 of explanatory notes to this Category) <b>Fee:</b> \$962.20 <b>Benefit:</b> 75% = \$721.65			
	PENIS, artificial	erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.)		
<b>Fee</b> 37426	Fee: \$1,014.05	<b>Benefit:</b> 75% = \$760.55		
		erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.)		
<b>Fee</b> 37429	Fee: \$336.30	<b>Benefit:</b> 75% = \$252.25		
		erection device, complete or partial revision or removal of components, with or without		
<b>Fee</b> 37432	Fee: \$962.20	<b>Benefit:</b> 75% = \$721.65		
<b>Fee</b> 37435	PENIS, frenuloplasty as an independent procedure (Anaes.)			

T8. SUF	RGICAL OPERAT	ONS	5. UROLOGICAL	
	Fee: \$97.10	<b>Benefit:</b> 75% = \$72.85 85% = \$82.55		
	Scrotum, partial	excision of, for histologically proven malign	ancy or infection (Anaes.) (Assist.)	
<b>Fee</b> 37438	Fee: \$287.80	<b>Benefit:</b> 75% = \$215.85 85% = \$244.65		
57450	1000 \$207.00	OPERATIONS ON TESTES, VASA OR	SEMINAL VESICLES	
SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Ana				
Fee				
37601	Fee: \$287.80	<b>Benefit:</b> 75% = \$215.85 85% = \$244.65		
Fee		rotal contents, with or without fixation and w an a service associated with sperm harvestin		
37604	Fee: \$287.80	<b>Benefit:</b> 75% = \$215.85 85% = \$244.65		
		perm retrieval, unilateral, from either the tes nic sperm injection, for male factor infertility		
<b>Fee</b> 37605	(See para TN.8.58) <b>Fee:</b> \$388.60	TN.1.5 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$291.45 85% = \$330.35		
	Open surgical sperm retrieval, unilateral, including the exploration of scrotal contents, with our without biopsy, for the purposes of intracytoplasmic sperm injection, for male factor infertility, performed in a hospital, excluding a service to which item 13218 or 37604 applies. (Anaes.)			
<b>Fee</b> 37606	(See para TN.1.5, <b>'</b> <b>Fee:</b> \$577.00	N.8.59 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$432.75 85% = \$492.30		
		itoneal lymph node dissection, for testicular which item 30390 or 30627 applies (Anaes.)		
<b>Fee</b> 37607	(See para TN.8.16) <b>Fee:</b> \$1,443.25	of explanatory notes to this Category) Benefit: 75% = \$1082.45		
	Bilateral retroperitoneal lymph node dissection, for testicular tumour, following previous si retroperitoneal dissection, retroperitoneal radiation therapy or chemotherapy, other than a s associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)		chemotherapy, other than a service	
<b>Fee</b> 37610	(See para TN.8.16) <b>Fee:</b> \$2,171.30	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$1628.50		
	EPIDIDYMECT	OMY (Anaes.)		
Fee 37613	Fee: \$287.80	<b>Benefit:</b> 75% = \$215.85 85% = \$244.65		
	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, n being a service associated with sperm harvesting for IVF (Anaes.) (Assist.)			
<b>Fee</b> 37616	Fee: \$719.40	<b>Benefit:</b> 75% = \$539.55		
		DMY or VASOEPIDIDYMOSTOMY, unila for IVF (Anaes.) (Assist.)	teral, not being a service associated with	
<b>Fee</b> 37619	Fee: \$287.80 Extended Medie	<b>Benefit:</b> 75% = \$215.85 85% = \$244.65 are Safety Net Cap: \$230.25		
<b>Fee</b> 37623	VASOTOMY O	R VASECTOMY, unilateral or bilateral		

T8. SUR	GICAL OPERATI	IONS	5. UROLOGICAL
	benefits are not p and Territory law	gal requirements apply in relation to sterilisa payable for services not rendered in accordan v. Observe the explanatory note before subm	nce with relevant Commonwealth and State
	(See para 11.8.46 <b>Fee:</b> \$239.20	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$179.40 85% = \$203.35	
		PAEDIATRIC GENITURINARY	SURGERY
Amend Fee		HUS, excision of, on a patient 10 years of ag	ge or over. (Anaes.) (Assist.)
37800	<b>Fee:</b> \$542.40	<b>Benefit:</b> 75% = \$406.80	
Amend Fee		HUS, excision of, when performed on a patient $\mathbf{P}_{\text{excision}} = (528.00)$	ent under 10 years of age (Anaes.) (Assist.)
37801	Fee: \$705.15	<b>Benefit:</b> 75% = \$528.90	
Amend Fee		D TESTIS, orchidopexy for, not being a serv of age or over. (Anaes.) (Assist.)	ice to which item 37806 applies, on a
37803	Fee: \$542.40	<b>Benefit:</b> 75% = \$406.80	
Amend Fee		D TESTIS, orchidopexy for, not being a serv 0 years of age (Anaes.) (Assist.)	ice to which item 37807 applies, on
37804	Fee: \$705.15	<b>Benefit:</b> 75% = \$528.90	
<b>Amend</b> <b>Fee</b> 37806	orchidopexy for,	D TESTIS in inguinal canal close to deep ing on a patient 10 years of age or over (Anaes.) Benefit: 75% = \$470.05 85% = \$542.00	
37800	Fee: \$626.70Benefit: 75% = \$470.0585% = \$542.00UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity,		
Amend Fee		on a patient under 10 years of age (Anaes.) (	
37807	Fee: \$814.70	<b>Benefit:</b> 75% = \$611.05 85% = \$730.00	
Amend Fee	UNDESCENDE (Assist.)	D TESTIS, revision orchidopexy for, on a pa	tient 10 years of age or over. (Anaes.)
37809	Fee: \$626.70	<b>Benefit:</b> 75% = \$470.05	
Amend	UNDESCENDEI (Assist.)	D TESTIS, revision orchidopexy for, on a pa	tient under 10 years of age (Anaes.)
Fee 37810	Fee: \$814.70	<b>Benefit:</b> 75% = \$611.05	
Amend		<b>FESTIS</b> , exploration of groin for, not being a 306 and 37809 applies, on a patient 10 years of	
Fee 37812	Fee: \$578.50	<b>Benefit:</b> 75% = \$433.90	
Amend Fee	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37804, 37807 and 37810 applies, on a patient under 10 years of age (Anaes.) (Assist.)		
<b>Fee</b> 37813	Fee: \$752.05	<b>Benefit:</b> 75% = \$564.05	
Amend Fee	-	, examination under anaesthesia with erectio	n test on a patient 10 years of age or over.
Fee 37815	Fee: \$96.50	<b>Benefit:</b> 75% = \$72.40	
		, examination under anaesthesia with erectio	1 10 0

T8. SUR	GICAL OPERAT	IONS 5. UROLOGICAL
<b>Fee</b> 37816	(Anaes.)	
	Fee: \$125.50	<b>Benefit:</b> 75% = \$94.15
Amend	HYPOSPADIAS (Anaes.) (Assist.	, glanuloplasty incorporating meatal advancement, on a patient 10 years of age or over
Fee 37818	Fee: \$511.35	<b>Benefit:</b> 75% = \$383.55 85% = \$434.65
Amend Fee	HYPOSPADIAS (Anaes.) (Assist.	, glanuloplasty incorporating meatal advancement, on a patient under 10 years of age
37819	Fee: \$664.80	<b>Benefit:</b> 75% = \$498.60 85% = \$580.10
Amend Fee	HYPOSPADIAS	, distal, 1 stage repair, on a patient 10 years of age or over. (Anaes.) (Assist.)
37821	Fee: \$866.90	<b>Benefit:</b> 75% = \$650.20
Amend	HYPOSPADIAS	, distal, 1 stage repair, on a patient under 10 years of age (Anaes.) (Assist.)
Fee 37822	Fee: \$1,126.95	<b>Benefit:</b> 75% = \$845.25
Amend Fee		, proximal, 1 stage repair, on a patient 10 years of age or over (Anaes.) (Assist.)
37824	Fee: \$1,205.25	<b>Benefit:</b> 75% = \$903.95
Amend Fee 37825	HYPOSPADIAS <b>Fee:</b> \$1,566.85	, proximal, 1 stage repair, on a patient under 10 years of age (Anaes.) (Assist.) Benefit: 75% = \$1175.15
Amend		benefit: 75% = \$1175.15 , staged repair, first stage, on a patient 10 years of age or over (Anaes.) (Assist.)
Fee 37827	Fee: \$555.25	<b>Benefit:</b> 75% = \$416.45
Amend Fee	HYPOSPADIAS	, staged repair, first stage, on a patient under 10 years of age (Anaes.) (Assist.)
37828	Fee: \$721.80	<b>Benefit:</b> 75% = \$541.35
Amend Fee		staged repair, second stage, on a patient 10 years of age or over (Anaes.) (Assist.)
37830	<b>Fee:</b> \$719.40	<b>Benefit:</b> 75% = \$539.55 85% = \$634.70
Amend Fee 37831	HYPOSPADIAS Fee: \$935.35	<ul> <li>Benefit: 75% = \$701.55 85% = \$850.65</li> </ul>
Amend		pair of urethral fistula, on a patient 10 years of age or over (Anaes.) (Assist.)
<b>Fee</b> 37833	<b>Fee:</b> \$343.35	<b>Benefit:</b> 75% = \$257.55
Amend Fee	Hypospadias, repair of urethral fistula, on a patient under 10 years of age (Anaes.) (Assist.)	
37834	Fee: \$446.35	<b>Benefit:</b> 75% = \$334.80
Fee	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.)	
37836	Fee: \$723.15	<b>Benefit:</b> 75% = \$542.40
	EPISPADIAS, st	aged repair, second stage (Anaes.) (Assist.)
<b>Fee</b> 37839	Fee: \$819.50	<b>Benefit:</b> 75% = \$614.65
<b>Fee</b> 37842		dder or epispadias, primary or secondary repair with or without bladder neck tightening, ireteric reimplantation (Anaes.) (Assist.)

T8. SUR	GICAL OPERATION	ONS 5.	UROLOGICAL	
	Fee: \$1,591.05	<b>Benefit:</b> 75% = \$1193.30		
	Congenital disord endoscopy (Anaes	er of sexual differentiation with urogenital sinus, external genitoplasty s.) (Assist.)	, with or without	
<b>Fee</b> 37845	Fee: \$723.15	<b>Benefit:</b> 75% = \$542.40		
_	Congenital disord and vaginoplasty	er of sexual differentiation with urogenital sinus, external genitoplasty (Anaes.) (Assist.)	with endoscopy	
<b>Fee</b> 37848	Fee: \$1,301.70	<b>Benefit:</b> 75% = \$976.30		
	Congenital disord (Assist.)	er of sexual differentiation, vaginoplasty for, with or without endoscop	py (Anaes.)	
<b>Fee</b> 37851	Fee: \$964.35	<b>Benefit:</b> 75% = \$723.30		
	Urethral valve, de	estruction of, including cystoscopy and urethroscopy (Anaes.)		
<b>Fee</b> 37854	Fee: \$381.30	<b>Benefit:</b> 75% = \$286.00		
T8. SUR	GICAL OPERATIO	ONS 6. CARE	DIO-THORACIO	
	Group T8. Surgio	al Operations		
		Subgroup 6. Cardio-Thoracic		
-	Trachea or bronch	nus, dilatation of stricture and endoscopic insertion of stent (Anaes.) (A	Assist.)	
<b>Fee</b> 38426 S	Fee: \$471.70	<b>Benefit:</b> 75% = \$353.80		
	CARDIOLOGY PROCEDURES			
	Right heart catheterisation with any one or more of the following:			
	(a) fluoroscopy;			
	(b) oximetry;			
	(c) dye dilution curves;			
	(d) cardiac output measurement by any method;			
	(e) shunt detection;			
	(f) exercise stress test;			
Amend	other than a service associated with a service to which item 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38254 or 38368 applies (Anaes.)			
<b>Fee</b> 38200	Fee: \$463.50	<b>Benefit:</b> 75% = \$347.65 85% = \$394.00		
		risation by percutaneous arterial puncture, arteriotomy or percutaneous y one or more of the following:	s left ventricular	
	(a) fluoroscopy;			
	(b) oximetry;			
Amend Fee 38203	(c) dye dilution cu	irves;		

T8. SUR	GICAL OPERATIONS 6. CARDIO-THORACIC
	(d) cardiac output measurements by any method;
	(e) shunt detection;
	(f) exercise stress test;
	other than a service associated with a service to which item 38200, 38206, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (Anaes.)
	<b>Fee:</b> \$553.10 <b>Benefit:</b> 75% = \$414.85 85% = \$470.15
	Right heart catheterisation with left heart catheterisation via the right heart or by another procedure, with any one or more of the following:
	(a) fluoroscopy;
	(b) oximetry;
	(c) dye dilution curves;
	(d) cardiac output measurements by any method;
	(e) shunt detection;
	(f) exercise stress test;
Amend Fee	other than a service associated with a service to which item 38200, 38203, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (Anaes.)
38206	<b>Fee:</b> \$668.70 <b>Benefit:</b> 75% = \$501.55 85% = \$584.00
	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.)
<b>Fee</b> 38209	(See para TN.8.60 of explanatory notes to this Category) <b>Fee:</b> \$858.60 <b>Benefit:</b> 75% = \$643.95 85% = \$773.90
	Cardiac electrophysiological study involving 4 or more catheters for:
	(a) supraventricular tachycardia investigation; or
	(b) complex tachycardia inductions; or
	(c) multiple catheter mapping; or
	(d) acute intravenous anti-arrhythmic drug testing with pre and post drug inductions; or
	(e) catheter ablation to intentionally induce complete atrioventricular block; or
	(f) intraoperative mapping;
	other than a service associated with a service to which item 38209 or 38213 applies (Anaes.)
<b>Amend</b> <b>Fee</b> 38212	(See para TN.8.60 of explanatory notes to this Category) <b>Fee:</b> \$1,428.05 <b>Benefit:</b> 75% = \$1071.05 85% = \$1343.35
Amend Fee	Cardiac electrophysiological study, performed either:

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC	
38213	(a) during insertion of implantable defibril	lator; or	
	(b) for defibrillation threshold testing at a d	different time to implantation;	
	other than a service associated with a servi	ice to which item 38209 or 38212 applies (Anaes.)	
	<b>Fee:</b> \$425.30 <b>Benefit:</b> 75% = \$319.0	00 85% = \$361.55	
	Use of a coronary pressure wire, if the serv	vice is:	
	(a) performed during selective coronary angiography, percutaneous angioplasty or transluminal insertion of one or more stents; and		
	(b) to measure fractional flow reserve, non intermediate coronary artery or graft lesion	n-hyperaemic pressure ratios or coronary flow reserve in ns (stenosis of 50 to 70%); and	
	(c) to determine whether revascularisation	is appropriate, if previous functional imaging:	
	(i) has not been performed; or		
	(ii) has been performed but the results are and	inconclusive or do not apply to the vessel being interrogated;	
	(d) performed on one or more coronary vas	scular territories	
Amend	(Anaes.)		
<b>Fee</b> 38241	<b>Fee:</b> \$488.70 <b>Benefit:</b> 75% = \$366.5	55 85% = \$415.40	
	Note: (acute coronary syndrome) the servic descriptor and the requirements of Note: T	ce only applies if the patient meets the requirements of the 'R.8.3 and TR.8.5	
	Selective coronary angiography:		
	(a) for a patient who is eligible for the serv	vice under clause 5.10.17A; and	
	(b) with placement of one or more catheters and injection of opaque material into native coronar arteries; and		
	(c) with or without left heart catheterisation	n, left ventriculography or aortography; and	
	(d) including all associated imaging;		
	other than a service associated with a servi 38251 or 38252 applies (Anaes.)	ice to which 38200, 38203, 38206, 38247, 38248, 38249,	
<b>New</b> 38244	<b>Fee:</b> \$920.00 <b>Benefit:</b> 75% = \$690.0	00 85% = \$835.30	
	Note: (acute coronary syndrome - graft) th the descriptor and the requirements of Note	the service only applies if the patient meets the requirements of the: TR.8.3 and TR.8.5	
	Selective coronary and graft angiography:		
	(a) for a patient who is eligible for the serv	vice under clause 5.10.17A; and	
<b>New</b> 38247	(b) with placement of one or more catheter arteries; and	rs and injection of opaque material into the native coronary	

T8. SUR	GICAL OPERATIONS O	6. CARDIO-THORACIC
	(c) if free coronary grafts attached to the aorta or direct internal mammary arter with placement of one or more catheters and injection of opaque material into t of the number of grafts); and	
	(d) with or without left heart catheterisation, left ventriculography or aortography	hy; and
	(e) including all associated imaging;	
	other than a service associated with a service to which item 38200, 38203, 3820 38251 or 38252 applies (Anaes.)	06, 38244, 38248, 38249,
	<b>Fee:</b> \$1,473.95 <b>Benefit:</b> 75% = \$1105.50 85% = \$1389.25	
	Note: (stable coronary syndrome) the service only applies if the patient meets the descriptor and the of Note: TR.8.2 and TR.8.5	he requirements of the
	Selective coronary angiography:	
	(a) for a patient who is eligible for the service under clause 5.10.17B; and	
	(b) as part of the management of the patient; and	
	(c) with placement of catheters and injection of opaque material into native cor	onary arteries; and
	(d) with or without left heart catheterisation, left ventriculography or aortography	hy; and
	(e) including all associated imaging;	
	other than a service associated with a service to which item 38200, 38203, 3820 38251 or 38252 applies—applicable each 3 months (Anaes.)	06, 38244, 38247, 38249,
New 38248	<b>Fee:</b> \$920.00 <b>Benefit:</b> 75% = \$690.00 85% = \$835.30	
	Note: (stable coronary syndrome - graft) the service only applies if the patient is the descriptor and the requirements of Note: TR.8.2 and TR.8.5	neets the requirements of
	Selective coronary and graft angiography:	
	(a) for a patient who is eligible for the service under clause 5.10.17B; and	
	(b) as part of the management of the patient; and	
	(c) with placement of one or more catheters and injection of opaque material in arteries; and	to native coronary
	(d) if free coronary grafts attached to the aorta or direct internal mammary arter with placement of one or more catheters and injection of opaque material into t of the number of grafts); and	
	(e) with or without left heart catheterisation, left ventriculography or aortograph	hy; and
	(f) including all associated imaging;	
	other than a service associated with a service to which item 38200, 38203, 3820 38251 or 38252 applies—applicable once each 3 months (Anaes.)	06, 38244, 38247, 38248,
<b>New</b> 38249	<b>Fee:</b> \$1,473.95 <b>Benefit:</b> 75% = \$1105.50 85% = \$1389.25	

T8. SURC	18. SURGICAL OPERATIONS       6. CARDIO-THORAC	
	Note: (pre-operative assessment) the service only applies if the patient descriptor and the requirements of Note: TR.8.5	meets the requirements of the
	Selective coronary angiography:	
	(a) for a symptomatic patient with valvular or other non-coronary struct	ctural heart disease; and
	(b) as part of the management of the patient for:	
	(i) pre-operative assessment for planning non-coronary cardiac su approaches; or	urgery, including by transcatheter
	(ii) evaluation of valvular heart disease or other non-coronary str clinical impression is discordant with non-invasive assessment; a	
	(c) with placement of catheters and injection of opaque material into n	ative coronary arteries; and
	(d) with or without left heart catheterisation, left ventriculography or a	ortography; and
	(e) including all associated imaging;	
	other than a service associated with a service to which item 38200, 382 38249 or 38252 applies—applicable once each 12 months (Anaes.)	203, 38206, 38244, 38247, 38248,
New 38251	<b>Fee:</b> \$920.00 <b>Benefit:</b> 75% = \$690.00 85% = \$835.30	
	Note: (pre-operative assessment - graft) the service only applies if the the descriptor and the requirements of Note: TR.8.5	patient meets the requirements of
	Selective coronary and graft angiography:	
	(a) for a symptomatic patient with valvular or other non-coronary struct	ctural heart disease; and
	(b) as part of the management of the patient for:	
	(i) pre-operative assessment for planning non-coronary cardiac su approaches; or	urgery, including by transcatheter
	(ii) evaluation of valvular heart disease or other non-coronary str clinical impression is discordant with non-invasive assessment; a	
	(c) with placement of one or more catheters and injection of opaque marteries; and	aterial into the native coronary
	(d) if free coronary grafts attached to the aorta or direct internal mamm with placement of one or more catheters and injection of opaque mater of the number of grafts); and	
	(e) with or without left heart catheterisation, left ventriculography or a	ortography; and
	(f) including all associated imaging;	
	other than a service associated with a service to which item 38200, 382 38249 or 38251 applies—applicable once each 12 months (Anaes.)	203, 38206, 38244, 38247, 38248,
New 38252	<b>Fee:</b> \$1,473.95 <b>Benefit:</b> 75% = \$1105.50 85% = \$1389.25	

T8. SUR	GICAL OPERATION	S	6. CARDIO-THORACIC
	Right heart catheteris	sation:	
	(a) performed at the applies; and	same time as service to which item	38244, 38247, 38248, 38249, 38251 or 38252
	(b) including any of	the following (if performed):	
	(i) fluoroscopy	;	
	(ii) oximetry;		
	(iii) dye dilutio	n curves;	
	(iv) cardiac out	put measurement;	
	(v) shunt detect	tion;	
	(vi) exercise str	ress test	
	(Anaes.)		
<b>New</b> 38254	<b>Fee:</b> \$463.50	<b>Benefit:</b> 75% = \$347.65 85% = \$3	94.00
	TEMPORARY TRA	NSVENOUS PACEMAKING EL	ECTRODE, insertion of (Anaes.)
Fee 38256	<b>Fee:</b> \$278.10	<b>Benefit:</b> 75% = \$208.60 85% = \$2	36.40
			RIAL SEPTOSTOMY, including cardiac
<b>Fee</b> 38270		re and after balloon dilatation (Ana Benefit: 75% = \$711.95 85% = \$8	
38270	-	r patent foramen closure:	
		art disease in a patient with docume	ented evidence of right heart overload or
	(b) using a septal occ	cluder or similar device, by transca	theter approach; and
	(c) including right or	left heart catheterisation (or both);	;
Amend Fee	other than a service a (Anaes.) (Assist.)	associated with a service to which i	tem 38200, 38203, 38206 or 38254 applies
38272	Fee: \$949.25	<b>Benefit:</b> 75% = \$711.95 85% = \$8	64.55
		sus, transcatheter closure of, includ ervice (Anaes.) (Assist.)	ling cardiac catheterisation and any imaging
Fee 38273	<b>Fee:</b> \$949.25	<b>Benefit:</b> 75% = \$711.95	
Amend	Ventricular septal de (Anaes.) (Assist.)	fect, transcatheter closure of, with	cardiac catheterisation, excluding imaging (H)
Fee 38274	<b>Fee:</b> \$777.60	<b>Benefit:</b> 75% = \$583.20	
-	MYOCARDIAL BIO	OPSY, by cardiac catheterisation (A	Anaes.)
Fee 38275	Fee: \$310.25	<b>Benefit:</b> 75% = \$232.70 85% = \$2	63.75

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC
	Transcatheter occlusion of left atrial appendage, and cardiac catheterisat practitioner, for stroke prevention in a patient who has non-valvular atria contraindication to life-long oral anticoagulation therapy, and is at increa- demonstrated by:	al fibrillation and a
	(a) a prior stroke (whether of an ischaemic or unknown type), transient i nervous system systemic embolism; or	schaemic attack or non-central
	(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 be	oth);
	(v) vascular disease (prior myocardial infarction, peripheral artery disease	se or aortic plaque)
	(Anaes.) (Assist.)	
<b>Fee</b> 38276	(See para TN.8.132 of explanatory notes to this Category)           Fee: \$949.25         Benefit: 75% = \$711.95	
	Insertion of implantable ECG loop recorder, by a specialist or consultant a primary disorder, including initial programming and testing, if:	t physician, for the diagnosis of
	(a) the patient has recurrent unexplained syncope and does not have a str with a high risk of sudden cardiac death; and	ructural heart defect associated
	(b) a diagnosis has not been achieved through all other available cardiac	investigations; and
	(c) a neurogenic cause is not suspected	
Amend	(Anaes.)	
Fee 38285	(See para TN.8.61 of explanatory notes to this Category)           Fee: \$160.55         Benefit: 75% = \$120.45         85% = \$136.50	
Amend	Removal of implantable ECG loop recorder (Anaes.)	
Fee 38286	<b>Fee:</b> \$144.60 <b>Benefit:</b> 75% = \$108.45 85% = \$122.95	
	Implantable loop recorder, insertion of, for diagnosis of atrial fibrillation	ı, if:
	(a) the patient to whom the service is provided has been diagnosed as ha undetermined source; and	ving had an embolic stroke of
	(b) the bases of the diagnosis included the following:	
	(i) the medical history of the patient;	
	(ii) physical examination;	
Fee 38288	(iii) brain and carotid imaging;	

T8. SUF	GICAL OPERATIONS 6. CARDIO-THORACIC
	(iv) cardiac imaging;
	(v) surface ECG testing including 24-hour Holter monitoring; and
	(c) atrial fibrillation is suspected; and
	(d) the patient:
	(i) does not have a permanent indication for oral anticoagulants; or
	(ii) does not have a permanent oral anticoagulants contraindication;
	including initial programming and testing
	(Anaes.)
	Fee: \$200.75         Benefit: 75% = \$150.60         85% = \$170.65
	CATHETER BASED ARRHYTHMIA ABLATION
-	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.)
Fee 38287	<b>Fee:</b> \$2,183.55 <b>Benefit:</b> 75% = \$1637.70 85% = \$2098.85
	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.)
Fee 38290	<b>Fee:</b> \$2,780.20 <b>Benefit:</b> 75% = \$2085.15
-	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.)
Fee 38293	<b>Fee:</b> \$2,984.25 <b>Benefit:</b> 75% = \$2238.20 85% = \$2899.55
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
	Note: (acute coronary syndrome - 1 coronary territory with selective coronary angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.3 and TR.8.5
	Percutaneous coronary intervention:
	(a) for a patient:
	(i) eligible for the service under clause 5.10.17A; and
	(ii) for whom selective coronary angiography has not been completed in the previous 3 months; and
	(b) including selective coronary angiography and all associated imaging, catheter and contrast; and
	(c) including either or both:
	(i) percutaneous angioplasty;
<b>New</b> 38307	(ii) transluminal insertion of one or more stents; and

T8. SUR	RGICAL OPERATIONS 6. CARDIO-THORA	
	(d) performed on one coronary vascular territory; and	
	(e) excluding aftercare;	
	other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38238249, 38251, 38252, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	248,
	<b>Fee:</b> \$1,844.60 <b>Benefit:</b> 75% = \$1383.45 85% = \$1759.90	
	Note: (acute coronary syndrome - 2 coronary territories with selective coronary angiography) the ser only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR and TR.8.5	
	Percutaneous coronary intervention:	
	(a) for a patient:	
	(i) eligible for the service under clause 5.10.17A; and	
	(ii) for whom selective coronary angiography has not been completed in the previous 3 months and	3;
	(b) including selective coronary angiography and all associated imaging, catheter and contrast; and	
	(c) including either or both:	
	(i) percutaneous angioplasty; and	
	(ii) transluminal insertion of one or more stents; and	
	(d) performed on 2 coronary vascular territories; and	
	(e) excluding aftercare;	
	other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38238249, 38251, 38252, 38307, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	248,
New 38308	<b>Fee:</b> \$2,122.25 <b>Benefit:</b> 75% = \$1591.70 85% = \$2037.55	
	Percutaneous transluminal rotational atherectomy of one or more coronary arteries, including all associated imaging, if:	
	(a) the target stenosis within at least one coronary artery is heavily calcified and balloon angioplasty with or without stenting is not feasible without rotational artherectomy; and	
	(b) the service is performed in conjunction with a service to which item 38307, 38308, 38310, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies	l,
	Applicable only once on each occasion the service is performed (Anaes.) (Assist.)	
<b>Amend</b> <b>Fee</b> 38309	(See para TN.8.41 of explanatory notes to this Category) <b>Fee:</b> \$1,250.70 <b>Benefit:</b> 75% = \$938.05 85% = \$1166.00	
<b>New</b> 38310	Note: (acute coronary syndrome - 3 coronary territories with selective coronary angiography) the set only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR	

T8. SURG	GICAL OPERATIONS 6. CAR	DIO-THORACIC
	and TR.8.5	
	Percutaneous coronary intervention:	
	(a) for a patient:	
	(i) eligible for the service under clause 5.10.17A; and	
	(ii) for whom selective coronary angiography has not been completed in the prev and	vious 3 months;
	(b) including selective coronary angiography and all associated imaging, catheter and	contrast; and
	(c) including either or both:	
	(i) percutaneous angioplasty; and	
	(ii) transluminal insertion of one or more stents; and	
	(d) performed on 3 coronary vascular territories; and	
	(e) excluding aftercare;	
	other than a service associated with a service to which item 38200, 38203, 38206, 382 38249, 38251, 38252, 38307, 38308, 38311, 38313, 38314, 38316, 38317, 38319, 383 38323 applies (Anaes.) (Assist.)	
	Fee: \$2,399.90 Benefit: 75% = \$1799.95 85% = \$2315.20	
	Note: (stable multi-vessel disease - 1 coronary territory with selective angiography) th applies if the patient meets the requirements of the descriptor and the requirements of TR.8.5	
	Percutaneous coronary intervention:	
	(a) for a patient:	
	(i) eligible under clause 5.10.17C for the service and a service to which item 383	14 applies; and
	(ii) for whom selective coronary angiography has not been completed in the prev and	vious 3 months;
	(b) including selective coronary angiography and all associated imaging, catheter and	contrast; and
	(c) including either or both:	
	(i) percutaneous angioplasty; and	
	(ii) transluminal insertion of one or more stents; and	
	(d) performed on one coronary vascular territory; and	
	(e) excluding aftercare;	
<b>New</b> 38311	other than a service associated with a service to which item 38200, 38203, 38206, 382 38249, 38251, 38252, 38307, 38308, 38310, 38313, 38314, 38316, 38317, 38319, 383	

T8. SUR	RGICAL OPERATIONS 6. CARDIO-THORACIO
	38323 applies (Anaes.) (Assist.)
	<b>Fee:</b> \$1,844.60 <b>Benefit:</b> 75% = \$1383.45 85% = \$1759.90
	Note: (stable multi-vessel disease - 2 coronary territories with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5
	Percutaneous coronary intervention:
	(a) for a patient:
	(i) eligible under clause 5.10.17C for the service and a service to which item 38314 applies; and
	(ii) for whom selective coronary angiography has not been completed in the previous 3 months; and
	(b) including selective coronary angiography and all associated imaging, catheter and contrast; and
	(c) including either or both:
	(i) percutaneous angioplasty; and
	(ii) transluminal insertion of one or more stents; and
	(d) performed on 2 coronary vascular territories; and
	(e) excluding aftercare;
	other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)
<b>New</b> 38313	<b>Fee:</b> \$2,122.25 <b>Benefit:</b> 75% = \$1591.70 85% = \$2037.55
	Note: (stable multi-vessel disease - 3 coronary territory with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5
	Percutaneous coronary intervention:
	(a) for a patient:
	(i) eligible for the service under clause 5.10.17C; and
	(ii) for whom selective coronary angiography has not been completed in the previous 3 months; and
	(b) including selective coronary angiography and all associated imaging, catheter and contrast; and
	(c) including either or both:
	(i) percutaneous angioplasty; and
	(ii) transluminal insertion of one or more stents; and
<b>New</b> 38314	(c) performed on 3 coronary vascular territories; and

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC
	(e) excluding aftercare;	
	other than a service associated with a service to which item 38200 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38316 38323 applies (Anaes.) (Assist.)	
	<b>Fee:</b> \$2,399.90 <b>Benefit:</b> 75% = \$1799.95 85% = \$2315.20	
	Note: (acute coronary syndrome - 1 coronary territory without sel applies if the patient meets the requirements of the descriptor and TR.8.5	
	Percutaneous coronary intervention:	
	(a) for a patient:	
	(i) eligible for the service under clause 5.10.17A; and	
	(ii) for whom selective coronary angiography has been comp	pleted in the previous 3 months; and
	(b) including any associated coronary angiography; and	
	(c) including either or both:	
	(i) percutaneous angioplasty; and	
	(ii) transluminal insertion of one or more stents; and	
	(d) performed on one coronary vascular territory; and	
	(e) excluding aftercare;	
	other than a service associated with a service to which item 38200 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314 38323 applies (Anaes.) (Assist.)	
<b>New</b> 38316	Fee: \$1,648.95 Benefit: 75% = \$1236.75 85% = \$1564.25	
	Note: (acute coronary syndrome - 2 coronary territories without so applies if the patient meets the requirements of the descriptor and TR.8.5	
	Percutaneous coronary intervention:	
	(a) for a patient:	
	(i) eligible for the service under clause 5.10.17A; and	
	(ii) for whom selective coronary angiography has been comp	pleted in the previous 3 months; and
	(b) including any associated coronary angiography; and	
	(c) including either or both:	
	(i) percutaneous angioplasty; and	
<b>New</b> 38317	(ii) transluminal insertion of one or more stents; and	

T8. SUR	GICAL OPERATIONS 6. CARDIO-THORACIC
	(d) performed on 2 coronary vascular territories; and
	(e) excluding aftercare;
	other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 3808, 38310, 38311, 38313, 38314, 38316, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)
	<b>Fee:</b> \$2,088.80 <b>Benefit:</b> 75% = \$1566.60 85% = \$2004.10
	Note: (acute coronary syndrome - 3 coronary territories without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.3 and TR.8.5
	Percutaneous coronary intervention:
	(a) for a patient:
	(i) eligible for the service under clause 5.10.17A; and
	(ii) for whom selective coronary angiography has been completed in the previous 3 months; and
	(b) including any associated coronary angiography; and
	(c) including either or both:
	(i) percutaneous angioplasty; and
	(ii) transluminal insertion of one or more stents; and
	(d) performed on 3 coronary vascular territories; and
	(e) excluding aftercare;
	other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38320, 38322 or 38323 applies (Anaes.) (Assist.)
<b>New</b> 38319	<b>Fee:</b> \$2,366.45 <b>Benefit:</b> 75% = \$1774.85 85% = \$2281.75
	Note: (stable multi-vessel disease - 1 coronary territory without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5
	Percutaneous coronary intervention:
	(a) for a patient:
	(i) eligible under clause 5.10.17C for the service and a service to which item 38323 applies; and
	(ii) for whom selective coronary angiography has been completed in the previous 3 months; and
	(b) including any associated coronary angiography; and
	(c) including either or both:
<b>New</b> 38320	(i) percutaneous angioplasty; and

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORAC	SIC
	(ii) transluminal insertion of one or more stents; and	
	(d) performed on one coronary vascular territory; and	
	(e) excluding aftercare;	
	other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 3824 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38322 or 38323 applies (Anaes.) (Assist.)	18,
	Fee: \$1,648.95         Benefit: 75% = \$1236.75         85% = \$1564.25	
	Note: (stable multi-vessel disease - 2 coronary territories with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 an TR.8.5	
	Percutaneous coronary intervention:	
	(a) for a patient:	
	(i) eligible under clause 5.10.17C for the service and a service to which item 38323 applies; and	
	(ii) for whom selective coronary angiography has been completed in the previous 3 months; and	
	(b) including any associated coronary angiography; and	
	(c) including either or both:	
	(i) percutaneous angioplasty; and	
	(ii) transluminal insertion of one or more stents; and	
	(d) performed on 2 coronary vascular territories; and	
	(e) excluding aftercare;	
	other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 3824 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38323 applies (Anaes.) (Assist.)	18,
<b>New</b> 38322	<b>Fee:</b> \$2,088.80 <b>Benefit:</b> 75% = \$1566.60 85% = \$2004.10	
	Note: (stable multi-vessel disease - 3 coronary territories with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 an TR.8.5	
	Percutaneous coronary intervention:	
	(a) for a patient:	
	(i) eligible for the service under clause 5.10.17C; and	
	(ii) for whom selective coronary angiography has been completed in the previous 3 months; and	
	(b) including any associated coronary angiography; and	
<b>New</b> 38323	(c) including either or both:	

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACIO
	(i) percutaneous angioplasty; and
	(ii) transluminal insertion of one or more stents; and
	(d) performed on 3 coronary vascular territories; and
	(e) excluding aftercare;
	other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38322 applies (Anaes.) (Assist.)
	Fee: \$2,366.45         Benefit: 75% = \$1774.85         85% = \$2281.75
	MISCELLANEOUS CARDIAC PROCEDURES
	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)
<b>Fee</b> 38350	(See para TN.8.60 of explanatory notes to this Category) <b>Fee:</b> \$664.55 <b>Benefit:</b> 75% = \$498.45
	PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)
<b>Fee</b> 38353	(See para TN.8.60 of explanatory notes to this Category) <b>Fee:</b> \$265.80 <b>Benefit:</b> 75% = \$199.35
	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)
<b>Fee</b> 38356	(See para TN.8.60 of explanatory notes to this Category) <b>Fee:</b> \$871.25 <b>Benefit:</b> 75% = \$653.45
	Extraction of one or more chronically implanted transvenous pacing or defibrillator leads, by percutaneous method, with locking stylets and snares, with extraction sheaths (if any), if:
	(a) the leads have been in place for more than 6 months and require removal; and
	(b) the service is performed:
	(i) in association with a service to which item 61109 or 60509 applies; and
	(ii) by a specialist or consultant physician who has undertaken the training to perform the service; and
	(iii) in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and
	(c) if the service is performed by an interventional cardiologist—a cardiothoracic surgeon is in attendance during the service
	(H) (Anaes.) (Assist.)
<b>Amend</b> <b>Fee</b> 38358	(See para TN.8.64 of explanatory notes to this Category) <b>Fee:</b> \$2,089.00 <b>Benefit:</b> 75% = \$1566.75

T8. SUF	GICAL OPERATIONS 6. CARDIO-THORACIC		
-	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.)		
Fee 38359	<b>Fee:</b> \$139.00 <b>Benefit:</b> 75% = \$104.25 85% = \$118.15		
-	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.)		
Fee 38362	<b>Fee:</b> \$400.50 <b>Benefit:</b> 75% = \$300.40 85% = \$340.45		
	Insertion, removal or replacement of permanent cardiac synchronisation device, if the patient:		
	(a) has all of the following:		
	(i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy);		
	(ii) left ventricular ejection fraction of less than 35%;		
	(iii) QRS duration of greater than or equal to 130 ms; or		
	(b) has all of the following:		
	(i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy);		
	(ii) left ventricular ejection fraction of less than 35%;		
	(iii) QRS duration of greater than or equal to 150 ms;		
	other than a service associated with a service to which item 38212 applies (H) (Anaes.) (Assist.)		
<b>Amend</b> <b>Fee</b> 38365	(See para TN.8.63 of explanatory notes to this Category) <b>Fee:</b> \$265.80 <b>Benefit:</b> 75% = \$199.35		
	Insertion, removal or replacement of permanent transvenous left ventricular electrode, through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venograms, if the patient:		
	(a) has all of the following:		
	(i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy);		
	(ii) left ventricular ejection fraction of less than 35%;		
	(iii) QRS duration of greater than or equal to 130 ms; or		
	(b) has all of the following:		
	(i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy);		
	(ii) left ventricular ejection fraction of less than 35%;		
	(iii) QRS duration of greater than or equal to 150 ms;		
Amend	other than a service associated with a service to which item 35200, 38200 or 38212 applies (H) (Anaes.) (Assist.)		
Fee 38368	(See para TN.8.63 of explanatory notes to this Category)		

T8. SUR	GICAL OPERATIO	ONS		6. CARDIO-THORACIC
	Fee: \$1,274.20	<b>Benefit:</b> 75% = \$955.65	5	
			ling insertion of patches for th has one of the following:	e insertion of one or more
	(a) a history of hae disease;	emodynamically signification	nt ventricular arrhythmias in t	he presence of structural heart
	(b) documented high	gh-risk genetic cardiac di	sease;	
			icular ejection fraction of less nd while on optimised medica	
			York Heart Association class I ptimised medical therapy);	I or III, with a left ventricular
N	other than a service	e to which item 38212 ap	plies (H) (Anaes.) (Assist.)	
New 38471	Fee: \$1,095.30	<b>Benefit:</b> 75% = \$821.50	)	
	· · · · · · · · · · · · · · · · · · ·	nent or removal of implan	table defibrillator generator, i	f the patient has one of the
	(a) a history of hae disease;	emodynamically significa	nt ventricular arrhythmias in t	he presence of structural heart
	(b) documented his	gh-risk genetic cardiac di	sease;	
			icular ejection fraction of less nd while on optimised medica	
	(d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricula ejection fraction of less than 35% (despite optimised medical therapy);			I or III, with a left ventricular
	other than a service	e to which item 38212 ap	plies (H) (Anaes.) (Assist.)	
New 38472	Fee: \$299.50	<b>Benefit:</b> 75% = \$224.65	5	
			ORACIC SURGERY	
	EMPYEMA, radic	al operation for, involvin	g resection of rib (Anaes.) (As	ssist.)
Fee 38415	<b>Fee:</b> \$415.55	<b>Benefit:</b> 75% = \$311.70	) 85% = \$353.25	
	Endoscopic ultraso	ound guided fine needle a	spiration biopsy or biopsies (e rom either or both of the follo	
	(a) mediastinal ma	sses;		
	(b) locoregional no	odes to stage non-small ce	ell lung carcinoma;	
	other than a service 38417 or 55054, ap		e to which an item in Subgrou	p 1 of this Group, or item
<b>Fee</b> 38416 S	(See para TN.8.21 of <b>Fee:</b> \$586.15	f explanatory notes to this C Benefit: 75% = \$439.65		
<b>Fee</b> 38417 S			biopsies (bronchoscopy with a obtain one or more speciment	

T8. SUR	GICAL OPERATIO	NS	6. CARDIO-THORACIC
	(a) transbronchial b	iopsy or biopsies of peripheral lung les	sions; or
	(b) fine needle aspin	rations of one or more mediastinal mas	sses; or
	(c) fine needle aspin	ations of locoregional nodes to stage r	non-small cell lung carcinoma;
		associated with a service to which an an item in Subgroup I5 of Group I3, a	item in Subgroup 1 of this Group, item 38416, pplies (Anaes.)
	(See para TN.8.21 of <b>Fee:</b> \$586.15	explanatory notes to this Category) <b>Benefit:</b> 75% = \$439.65 85% = \$501.	.45
-	THORACOTOMY	exploratory, with or without biopsy (	Anaes.) (Assist.)
Fee 38418	Fee: \$997.25	<b>Benefit:</b> 75% = \$747.95	
	Bronchoscopy, as a	n independent procedure (Anaes.)	
Fee 38419 S	Fee: \$185.25	<b>Benefit:</b> 75% = \$138.95 85% = \$157.	.50
			r other diagnostic or therapeutic procedures
Fee 38420 S	Fee: \$244.60	<b>Benefit:</b> 75% = \$183.45 85% = \$207.	95
	THORACOTOMY	with pulmonary decortication (Anaes	s.) (Assist.)
Fee 38421	Fee: \$1,594.05	<b>Benefit:</b> 75% = \$1195.55	
	Bronchus, removal	of foreign body in (Anaes.) (Assist.)	
Fee 38422 S	Fee: \$382.65	<b>Benefit:</b> 75% = \$287.00	
	Fibreoptic bronchos		lung biopsies, with or without bronchial or entional imaging (Anaes.) (Assist.)
Fee 38423 S	Fee: \$267.35	<b>Benefit:</b> 75% = \$200.55 85% = \$227.	.25
	THORACOTOMY (Anaes.) (Assist.)	with pleurectomy or pleurodesis, OR	ENUCLEATION OF HYDATID cysts
Fee 38424	Fee: \$997.25	<b>Benefit:</b> 75% = \$747.95	
	±	section of endobronchial tumours for r res (Anaes.) (Assist.)	relief of obstruction including any associated
Fee 38425 S	Fee: \$628.75	<b>Benefit:</b> 75% = \$471.60	
	THORACOPLASTY (complete) - 3 or more ribs (Anaes.) (Assist.)		) (Assist.)
Fee 38427	<b>Fee:</b> \$1,231.40	<b>Benefit:</b> 75% = \$923.55	
		Y (in stages) each stage (Anaes.) (As	sist.)
Fee 38430	<b>Fee:</b> \$634.60	<b>Benefit:</b> 75% = \$475.95	
	THORACOSCOPY		dhesions, including insertion of intercostal
Fee 38436	Fee: \$259.85	<b>Benefit:</b> 75% = \$194.90	
Fee 38438	PNEUMONECTO	AY or LOBECTOMY or SEGMENTE	ECTOMY not being a service associated with a

T8. SUF	T8. SURGICAL OPERATIONS6. CARDIO-TH	
	service to which I	tem 38418 applies (Anaes.) (Assist.)
	Fee: \$1,594.05	<b>Benefit:</b> 75% = \$1195.55
	LUNG, wedge res	section of (Anaes.) (Assist.)
<b>Fee</b> 38440	Fee: \$1,193.70	<b>Benefit:</b> 75% = \$895.30
		ECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm,
Fee	pericardium, or fo	ormal mediastinal node dissection (Anaes.) (Assist.)
38441	Fee: \$1,888.75	<b>Benefit:</b> 75% = \$1416.60
	THORACOTOM	Y or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.)
Fee 38446	Fee: \$1,231.40	<b>Benefit:</b> 75% = \$923.55
	PERICARDIECT (Anaes.) (Assist.)	OMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass
Fee 38447	Fee: \$1,594.05	<b>Benefit:</b> 75% = \$1195.55
		, cervical exploration of, with or without biopsy (Anaes.) (Assist.)
Fee 38448	<b>Fee:</b> \$377.75	<b>Benefit:</b> 75% = \$283.35
50110		OMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass
	(Anaes.) (Assist.)	
Fee 38449	Fee: \$2,230.05	<b>Benefit:</b> 75% = \$1672.55
	PERICARDIUM, transthoracic open surgical drainage of (Anaes.) (Assist.)	
Fee 38450	<b>Fee:</b> \$891.35	<b>Benefit:</b> 75% = \$668.55
	PERICARDIUM,	subxiphoid open surgical drainage of (Anaes.) (Assist.)
Fee 38452	<b>Fee:</b> \$596.95	<b>Benefit:</b> 75% = \$447.75
		sion and repair without cardiopulmonary bypass (Anaes.) (Assist.)
Fee 38453	Fee: \$1,790.65	<b>Benefit:</b> 75% = \$1343.00
36433		CISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.)
Fee		
38455	<b>Fee:</b> \$2,422.00	<b>Benefit:</b> 75% = \$1816.50
	INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Grapplies (Anaes.) (Assist.)	
Fee 38456	Fee: \$1,594.05	<b>Benefit:</b> 75% = \$1195.55
		ATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.)
Fee 38457	<b>Fee:</b> \$1,488.20	<b>Benefit:</b> 75% = \$1116.15
50 157		ATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.)
<b>Fee</b> 38458	Fee: \$793.25	<b>Benefit:</b> 75% = \$594.95
50450		C OR WIRES, removal of (Anaes.)
Fee		
38460	Fee: \$286.55	<b>Benefit:</b> 75% = \$214.95

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC
	STERNOTOMY WOUND, debridement of, 1	not involving reopening of the mediastinum (Anaes.)
Fee 38462	<b>Fee:</b> \$339.65 <b>Benefit:</b> 75% = \$254.75	
-	STERNOTOMY WOUND, debridement of, i removal of wires but not involving reopening	nvolving curettage of infected bone with or without of the mediastinum (Anaes.)
Fee 38464	<b>Fee:</b> \$369.20 <b>Benefit:</b> 75% = \$276.90	
Б	STERNUM, reoperation on, for dehiscence of without rewiring (Anaes.) (Assist.)	r infection involving reopening of the mediastinum, with or
<b>Fee</b> 38466	<b>Fee:</b> \$996.85 <b>Benefit:</b> 75% = \$747.65	
F	STERNUM AND MEDIASTINUM, reoperat or greater omentum (Anaes.) (Assist.)	ion for infection of, involving muscle advancement flaps
Fee 38468	<b>Fee:</b> \$1,535.95 <b>Benefit:</b> 75% = \$1152.00	
	STERNUM AND MEDIASTINUM, reoperat and greater omentum (Anaes.) (Assist.)	tion for infection of, involving muscle advancement flaps
Fee 38469	<b>Fee:</b> \$1,790.65 <b>Benefit:</b> 75% = \$1343.00	
	CARDIAC S	URGERY PROCEDURES
New		ent myocardial electrode, by open surgical approach, other ich item 11704, 11705, 11707, 11714, 18260, 33824, Assist.)
38467	<b>Fee:</b> \$997.25 <b>Benefit:</b> 75% = \$747.95	
	VALVU	LAR PROCEDURES
	TMVr, by transvenous or transeptal technique one or more Mitraclips <sup>™</sup> , including intra-ope	es, for permanent coaptation of mitral valve leaflets using prative diagnostic imaging, if:
	(a) the patient has each of the following	risk factors:
	(i) moderate to severe, or severe, regurgitation (grade 3+ or 4+);	symptomatic degenerative (primary) mitral valve
	(ii) left ventricular ejection fraction	on of 20% or more;
	(iii) symptoms of mild, moderate Association class II, III or IV); and	or severe chronic heart failure (New York Heart
	(b) as a result of a TMVr suitability case	e conference, the patient has been:
	(i) assessed as having an unaccept	ably high risk for surgical mitral valve replacement; and
	(ii) recommended as being suitable	e for the service; and
	(c) the service is performed:	
	(i) by a cardiothoracic surgeon, or accreditation committee to perform	an interventional cardiologist, accredited by the TMVr n the service; and
<b>New</b> 38461	(ii) via transfemoral venous delive or not feasible; and	ry, unless transfemoral venous delivery is contraindicated

T8. SURG	GICAL OPERATIONS 6. CARDIO-THORACIC
	(iii) in a hospital that is accredited by the TMVr accreditation committee as a suitable hospital for the service; and
	(d) a service to which this item, or item 38463, applies has not been provided to the patient in the previous 5 years
	(H) (Anaes.) (Assist.)
	<b>Fee:</b> \$1,490.25 <b>Benefit:</b> 75% = \$1117.70
	TMVr, by transvenous or transeptal techniques, for permanent coaptation of mitral valve leaflets using one or more Mitraclips <sup>™</sup> , including intra-operative diagnostic imaging, if:
	(a) the patient has each of the following risk factors:
	(i) moderate to severe, or severe, symptomatic functional (secondary) mitral valve regurgitation (grade 3+ or 4+);
	(ii) left ventricular ejection fraction of 20% to 50%;
	(iii) left ventricular end systolic diameter of not more than 70mm;
	(iv) symptoms of mild, moderate or severe chronic heart failure (New York Heart Association class II, III or IV) that persist despite maximally tolerated guideline directed medical therapy; and
	(b) as a result of a TMVr suitability case conference, the patient has been:
	(i) assessed as having an unacceptably high risk for surgical mitral valve replacement; and
	(ii) recommended as being suitable for the service; and
	(c) the service is performed:
	(i) by a cardiothoracic surgeon, or an interventional cardiologist, accredited by the TMVr accreditation committee to perform the service; and
	(ii) via transfemoral venous delivery, unless transfemoral venous delivery is contraindicated or not feasible; and
	(iii) in a hospital that is accredited by the TMVr accreditation committee as a suitable hospital for the service; and
	(d) a service to which this item, or item 38461, applies has not been provided to the patient in the previous 5 years
	(H) (Anaes.) (Assist.)
<b>New</b> 38463	<b>Fee:</b> \$1,490.25 <b>Benefit:</b> 75% = \$1117.70
	Valve annuloplasty with insertion of ring, other than:
	(a) a service to which item 38516 or 38517 applies; or
<b>Amend</b> <b>Fee</b> 38477	(b) a service associated with a service to which to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC
	(H) (Anaes.) (Assist.)	
	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,084.55 <b>Benefit:</b> 75% = \$1563.45	
Norr	Aortic or pulmonary valve replacement with bioprosthesis or retrograde cardioplegia (if performed), other than a service a 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 o	ssociated with a service to which item
<b>New</b> 38484	<b>Fee:</b> \$2,112.20 <b>Benefit:</b> 75% = \$1584.15	
	MITRAL ANNULUS, reconstruction of, after decalcificatio surgery (Anaes.) (Assist.)	n, when performed in association with valve
<b>Fee</b> 38485	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$850.20 <b>Benefit:</b> 75% = \$637.65	
	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.)	
<b>Fee</b> 38487	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,790.65 <b>Benefit:</b> 75% = \$1343.00	
	Reconstruction and re-implantation of sub-valvular structure to which item 38499 applies (H) (Anaes.) (Assist.)	es, if performed in conjunction with a service
<b>Amend</b> <b>Fee</b> 38490	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$577.00 <b>Benefit:</b> 75% = \$432.75	
	OPERATIVE MANAGEMENT of acute infective endocard (Anaes.) (Assist.)	itis, in association with heart valve surgery
<b>Fee</b> 38493	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,036.90 <b>Benefit:</b> 75% = \$1527.70	
	TAVI, for the treatment of symptomatic severe aortic stenos unless transfemoral delivery is contraindicated or not feasibl a TAVI Practitioner – includes all intraoperative diagnostic i upon the TAVI Patient.	e, in a TAVI Hospital on a TAVI Patient by
	(Not payable more than once per patient in a five year period	l.) (Anaes.) (Assist.)
<b>Fee</b> 38495	(See para AN.33.1, TN.8.135 of explanatory notes to this Category           Fee: \$1,490.25         Benefit: 75% = \$1117.70         85% = \$1405.	
	Mitral or tricuspid valve replacement with bioprothesis or m cardioplegia (if performed), other than a service associated v 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies	vith a service to which item 11704, 11705,
<b>New</b> 38499	<b>Fee:</b> \$2,112.20 <b>Benefit:</b> 75% = \$1584.15	
	Simple valve repair:	
	(a) with or without annuloplasty; and	
	(b) including quadrangular resection, cleft closure or alfieri;	and
	(c) including retrograde cardioplegia (if performed);	
<b>New</b> 38516	other than a service associated with a service to which item 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	11704, 11705, 11707, 11714, 18260, 33824,

T8. SUR	GICAL OPERATIONS 6. CARDIO-THORACIO
	<b>Fee:</b> \$2,509.25 <b>Benefit:</b> 75% = \$1881.95
	Complex valve repair:
	(a) with or without annuloplasty; and
	(b) including retrograde cardioplegia (if performed); and
	(c) including one of the following:
	(i) neochords;
	(ii) chordal transfer;
	(iii) patch augmentation;
	(iv) multiple leaflets;
N	other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)
<b>New</b> 38517	<b>Fee:</b> \$3,055.85 <b>Benefit:</b> 75% = \$2291.90
	Valve explant of a previous prosthesis, if performed during a service to which item 38484 or 38499 applies, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)
New 38519	<b>Fee:</b> \$1,100.00 <b>Benefit:</b> 75% = \$825.00
	SURGERY FOR ISCHAEMIC HEART DISEASE
	Coronary artery bypass, including cardiopulmonary bypass, with or without retrograde cardioplegia, with or without vein grafts, and including at least one of the following:
	(a) harvesting of left internal mammary artery and vein graft material;
	(b) harvesting of left internal mammary artery;
	(c) harvesting of vein graft material;
	other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)
New 38502	<b>Fee:</b> \$2,451.55 <b>Benefit:</b> 75% = \$1838.70
	Repair or reconstruction of left ventricular aneurysm, including plication, resection and primary and patch repairs, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)
<b>Amend</b> <b>Fee</b> 38508	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,996.20 <b>Benefit:</b> 75% = \$1497.15
	Repair of ischaemic ventricular septal rupture,, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)
Amend Fee 38509	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,485.45 <b>Benefit:</b> 75% = \$1864.10
<b>New</b> 38510	Artery harvesting (other than of the left internal mammary), for coronary artery bypass, if:

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC
	(a) more than one arterial graft is required; and	
	(b) the service is performed in conjunction with a serv	ice to which item 38502 applies
	(H) (Anaes.) (Assist.)	
	<b>Fee:</b> \$649.25 <b>Benefit:</b> 75% = \$486.95	
	Coronary artery bypass, with the aid of tissue stabilise	rs, if the service is performed:
	(a) without cardiopulmonary bypass; and	
	(b) in conjunction with a service to which item 38502	applies
	(H) (Anaes.) (Assist.)	
<b>New</b> 38511	<b>Fee:</b> \$624.30 <b>Benefit:</b> 75% = \$468.25	
N	Creation of graft anastomosis, including Y-graft, T-grarterial or micro-venous anastomosis using microsurgic conjunction with a service to which item 38502 applied	ical techniques, if the service is performed in
New 38513	<b>Fee:</b> \$1,040.55 <b>Benefit:</b> 75% = \$780.45	
	ARRHYTHMIA	SURGERY
	Division of accessory pathway, isolation procedure, patissues involving one atrial chamber only, other than a 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38	service associated with a service to which item
<b>Amend</b> <b>Fee</b> 38512	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,183.55 Benefit: 75% = \$1637.70	
	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	
<b>Amend</b> <b>Fee</b> 38515	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,780.20 <b>Benefit:</b> 75% = \$2085.15	
	Ventricular arrhythmia with mapping and muscle abla a service associated with a service to which item 1170 38806 or 45503 applies (H) (Anaes.) (Assist.)	
<b>Amend</b> <b>Fee</b> 38518	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,984.25 <b>Benefit:</b> 75% = \$2238.20	
	PROCEDURES ON T	HORACIC AORTA
	Repair or replacement of ascending thoracic aorta:	
	(a) including:	
	(i) cardiopulmonary bypass; and	
	(ii) retrograde cardioplegia (if performed); and	
Amend	(b) not including valve replacement or repair or impla	ntation of coronary arteries;
Fee	other than a service associated with a service to which	

T8. SUR	GICAL OPERATIONS 6. CARDIO-THORACIC
	38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)
	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,337.50 <b>Benefit:</b> 75% = \$1753.15
	Repair or replacement of ascending thoracic aorta:
	(a) including:
	(i) aortic valve replacement or repair; and
	(i) cardiopulmonary bypass; and
	(ii) retrograde cardioplegia (if performed); and
	(b) not including implantation of coronary arteries;
	other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)
Amend Fee 38553	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,942.90 <b>Benefit:</b> 75% = \$2207.20
	Valve sparing aortic root surgery, with reimplantation of aortic valve and coronary arteries and replacement of the ascending aorta, including cardiopulmonary bypass, and including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)
<b>New</b> 38554	<b>Fee:</b> \$4,236.45 <b>Benefit:</b> 75% = \$3177.35
	Simple replacement or repair of aortic arch, performed in conjunction with a service to which item 38550, 38553, 38554, 38556, 38568 or 38571 applies, including:
	(a) deep hypothermic circulatory arrest; and
	(b) peripheral cannulation for cardiopulmonary bypass; and
	(c) antegrade or retrograde cerebral perfusion (if performed);
	other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38603, 38806 or 45503 applies (H) (Anaes.) (Assist.)
<b>New</b> 38555	<b>Fee:</b> \$3,374.00 <b>Benefit:</b> 75% = \$2530.50
	Repair or replacement of ascending thoracic aorta, including:
	(a) aortic valve replacement or repair; and
	(b) implantation of coronary arteries; and
	(c) cardiopulmonary bypass; and
	(d) retrograde cardioplegia (if performed);
	other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38603, 38806 or 45503 applies (H) (Anaes.) (Assist.)
<b>Amend</b> <b>Fee</b> 38556	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$3,230.50 <b>Benefit:</b> 75% = \$2422.90

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC
	Complex replacement or repair of aortic arch, performed in con 38550, 38553, 38554, 38556, 38568 or 38571 applies, including	
	(a) debranching and reimplantation of head and neck vessels; an	nd
	(b) deep hypothermic circulatory arrest; and	
	(c) peripheral cannulation for cardiopulmonary bypass; and	
	(d) antegrade or retrograde cerebral perfusion (if performed);	
	other than a service associated with a service to which item 117 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	04, 11705, 11707, 11714, 18260, 33824,
<b>New</b> 38557	<b>Fee:</b> \$3,894.30 <b>Benefit:</b> 75% = \$2920.75	
	Aortic repair involving augmentation of hypoplastic or interrupt	ted aortic arch, if:
	(a) the patient is a neonate; and	
	(b) the service includes:	
	(i) the use of antegrade cerebral perfusion or deep hypothermic myocardial preservation; and	circulatory arrest and associated
	(ii) retrograde cardioplegia;	
	other than a service associated with a service to which item 117 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	04, 11705, 11707, 11714, 18260, 33824,
<b>New</b> 38558	<b>Fee:</b> \$5,083.70 <b>Benefit:</b> 75% = \$3812.80	
	Repair or replacement of descending thoracic aorta, without shu exposure, percutaneous or endovascular means, other than a ser item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806	vice associated with a service to which
<b>Amend</b> <b>Fee</b> 38568	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,938.45 <b>Benefit:</b> 75% = \$1453.85	
	Repair or replacement of descending thoracic aorta, with shunt service associated with a service to which item 11704, 11705, 1 38806 or 45503 applies (H) (Anaes.) (Assist.)	
Amend Fee 38571	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,209.65 <b>Benefit:</b> 75% = \$1657.25	
	Operative management of acute rupture or dissection, if the serv	vice:
	(a) is performed in conjunction with a service to which item 385 38558, 38568, 38571, 38706 or 38709 applies; and	550, 38553, 38554, 38555, 38556, 38557,
	(b) is not associated with a service to which item 11704, 11705, 38806 or 45503 applies	, 11707, 11714, 18260, 33824, 38418,
	(H) (Anaes.) (Assist.)	
Amend Fee 38572	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,067.60 <b>Benefit:</b> 75% = \$1550.70	
	CIRCULATORY SUPPORT PRO	CEDURES

T8. SUR	GICAL OPERATIONS 6. CARDIO-THORACIO
	CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.)
<b>Fee</b> 38600	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,594.05 <b>Benefit:</b> 75% = \$1195.55
	Peripheral cannulation for cardiopulmonary bypass, excluding post-operative management, other than a service:
	(a) in which peripheral cannulation is used in preference to central cannulation for valve or coronary bypass procedures; or
	(b) associated with a service to which item 38555 or 38572 applies
Amend	(H) (Anaes.) (Assist.)
Fee 38603	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$997.25 <b>Benefit:</b> 75% = \$747.95
	Insertion of intra-aortic balloon pump, by arteriotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)
Amend Fee 38609	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$498.55 <b>Benefit:</b> 75% = \$373.95
	Removal of intra-aortic balloon pump, with closure of artery by direct suture, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)
<b>Amend</b> <b>Fee</b> 38612	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$558.90 <b>Benefit:</b> 75% = \$419.20
	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;
	other than a service associated with a service to which:
	(d) item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies; or
	(e) another item in this Schedule applies if the service described in the item is for the use of a ventricula assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation
Amend	(H) (Anaes.) (Assist.)
Fee 38615	(See para TN.8.67 of explanatory notes to this Category)

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC	
	<b>Fee:</b> \$1,594.05 <b>Benefit:</b> 75% = \$1195.55		
	Insertion of a left and right ventricular assist device, for use as:		
	(a) a bridge to cardiac transplantation in patients with refractory heart fa	ailure 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 ventricular assist device; or		
	(b) acute post cardiotomy support for failure to wean from cardiopulmo	onary transplantation; or	
	(c) cardio-respiratory support for acute cardiac failure which is likely to of less than 6 weeks;	o recover with short term support	
	other than a service associated with a service to which:		
	(d) item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 4	45503 applies; or	
	(e) another item in this Schedule applies if the service described in the is assist device as destination therapy in the management of a patient with to be a suitable candidate for cardiac transplantation		
	(H) (Anaes.) (Assist.)		
<b>Amend</b> <b>Fee</b> 38618	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,986.95 <b>Benefit:</b> 75% = \$1490.25		
	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as than a service associated with a service to which item 11704, 11705, 11 38418, 38627, 38806 or 45503 applies (H) (Anaes.) (Assist.)		
Amend Fee 38621	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$793.25 <b>Benefit:</b> 75% = \$594.95		
	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, a other than a service associated with a service to which item 11704, 117 38418, 38627, 38806 or 45503 applies (H) (Anaes.) (Assist.)		
Amend Fee 38624	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$891.35 <b>Benefit:</b> 75% = \$668.55		
	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS O DEVICE CANNULAE, adjustment and re-positioning of, by open oper these devices, other than a service associated with a service to which ite 18260, 33824, 38418, 38627, 38806 or 45503 applies	ration, in patients supported by	
	(H) (Anaes.) (Assist.)		
<b>Amend</b> <b>Fee</b> 38627	(See para TN.8.67 of explanatory notes to this Category)           Fee:         \$696.70         Benefit:         75% = \$522.55		
	RE-OPERATION		
Amend	PATENT DISEASED coronary artery bypass vein graft or grafts, disservices oversewing of, other than a service associated with a service to which it 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)		
<b>Fee</b> 38637	(See para TN.8.67 of explanatory notes to this Category)		

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC
	<b>Fee:</b> \$577.00 <b>Benefit:</b> 75% = \$432.75	
	MISCELLANEOUS CARDIOTHORACIC SURGICAL	PROCEDURES
	Re-operation via thoracotomy or sternotomy, by any procedure:	
	(a) including any division of adhesions if the time taken to divide the ad	dhesions exceeds 30 minutes; and
	(b) other than a service associated with a service to which item 11704, 33824, 38418, 38806 or 45503 applies	11705, 11707, 11714, 18260,
	(H) (Anaes.) (Assist.)	
Amend Fee 38643	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,567.65 <b>Benefit:</b> 75% = \$1175.75	
	Open heart surgery, other than a service:	
	(a) to which another item in this Group applies; or	
A	(b) associated with a service to which item 11704, 11705, 11707, 11714 45503 applies (H) (Anaes.) (Assist.)	4, 18260, 33824, 38418, 38806 or
<b>Amend</b> <b>Fee</b> 38653	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,090.50 <b>Benefit:</b> 75% = \$1567.90	
	THORACOTOMY or median sternotomy for post-operative bleeding, of with a service to which item 11704, 11705, 11707, 11714, 18260, 3382 (H) (Anaes.) (Assist.)	
<b>Amend</b> <b>Fee</b> 38656	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$997.25 <b>Benefit:</b> 75% = \$747.95	
	Ventricular myectomy, for relief of right or left ventricular obstruction, with a service to which item 11704, 11705, 11707, 11714, 18260, 3382 (H) (Anaes.) (Assist.)	
New 38764	<b>Fee:</b> \$2,221.00 <b>Benefit:</b> 75% = \$1665.75	
30704	CARDIAC TUMOURS	
	CARDIAC TUMOUR, excision of, involving the wall of the atrium or or conduit reconstruction, other than a service associated with a service 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anae	to which item 11704, 11705,
<b>Amend</b> <b>Fee</b> 38670	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,986.55 <b>Benefit:</b> 75% = \$1489.95	
	CARDIAC TUMOUR, excision of, involving the wall of the atrium or reconstruction with patch or conduit, other than a service associated wit 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H	th a service to which item 11704,
<b>Amend</b> <b>Fee</b> 38673	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,235.95 <b>Benefit:</b> 75% = \$1677.00	
	CARDIAC TUMOUR arising from ventricular myocardium, partial this service associated with a service to which item 11704, 11705, 11707, 1 38806 or 45503 applies (H) (Anaes.) (Assist.)	
<b>Amend</b> <b>Fee</b> 38677	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,091.80 <b>Benefit:</b> 75% = \$1568.85	

T8. SUR	GICAL OPERATIONS 6. CARDIO-THORA	CIC
Amend Fee	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repa or reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	air
38680	<b>Fee:</b> \$2,481.20 <b>Benefit:</b> 75% = \$1860.90	
	CONGENITAL CARDIAC SURGERY	
New	Repair, augmentation or replacement of branch pulmonary arteries—left or right (or both), with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	
38474	<b>Fee:</b> \$2,257.10 <b>Benefit:</b> 75% = \$1692.85	
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H (Anaes.) (Assist.)	
Amend Fee 38700	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,110.65 <b>Benefit:</b> 75% = \$833.00	
	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	
Amend Fee 38703	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,008.85 <b>Benefit:</b> 75% = \$1506.65	
	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, oth than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	ler
<b>Amend</b> <b>Fee</b> 38706	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,896.20 <b>Benefit:</b> 75% = \$1422.15	
	Anastomosis or repair of aorta, with cardiopulmonary bypass, for congenital heart disease, other than service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	ı a
<b>Amend</b> <b>Fee</b> 38709	(See para TN.8.67 of explanatory notes to this Category)           Fee: \$2,235.45         Benefit: 75% = \$1676.60	
	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	, for
<b>Amend</b> <b>Fee</b> 38715	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,775.45 <b>Benefit:</b> 75% = \$1331.60	
A	Banding, debanding or repair of main pulmonary artery, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	
<b>Amend</b> <b>Fee</b> 38718	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,245.70 <b>Benefit:</b> 75% = \$1684.30	
Amend Fee	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart diseas other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 338	

T8. SURGICAL OPERATIONS6. CARDIO-THOP		
38721	38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	
	(See para TN.8.67 of explanatory notes to this Category)           Fee: \$1,556.45         Benefit: 75% = \$1167.35	
	Vena cava, anastomosis or repair of, with cardiopulmonary byp than a service associated with a service to which item 11704, 1 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	
Amend Fee 38724	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,264.55 Benefit: 75% = \$1698.45	
	Anastomosis or repair of intrathoracic vessels, without cardiopu procedure, other than a service to which item 11704, 11705, 11 38703, 38706, 38709, 38712, 38715, 38718, 38721, 38724, 388 (Assist.)	707, 11714, 18260, 33824, 38418, 38700,
Amend Fee 38727	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,556.45 <b>Benefit:</b> 75% = \$1167.35	
	Anastomosis or repair of intrathoracic vessels, with cardiopulm procedure, other than a service to which item 11704, 11705, 11 38703, 38706, 38709, 38712, 38715, 38718, 38721, 38724, 388 (Assist.)	707, 11714, 18260, 33824, 38418, 38700,
<b>Amend</b> <b>Fee</b> 38730	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> $$2,221.00$ <b>Benefit:</b> 75% = $$1665.75$	
	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUN bypass, for congenital heart disease, other than a service associa 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 ap	ated with a service to which item 11704,
<b>Amend</b> <b>Fee</b> 38733	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,556.45 <b>Benefit:</b> 75% = \$1167.35	
	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUN bypass, for congenital heart disease, other than a service associa 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 ap	ated with a service to which item 11704,
<b>Amend</b> <b>Fee</b> 38736	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,221.00 Benefit: 75% = \$1665.75	
	Atrial septectomy, with or without cardiopulmonary bypass, for service associated with a service to which item 11704, 11705, 1 38806 or 45503 applies (H) (Anaes.) (Assist.)	6
<b>Amend</b> <b>Fee</b> 38739	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,036.55 <b>Benefit:</b> 75% = \$1527.45	
	Atrial septal defect, closure by open exposure and direct suture patient with documented evidence of right heart overload or parassociated with a service to which item 11704, 11705, 11707, 145503 applies (H) (Anaes.) (Assist.)	radoxical embolism, other than a service
Amend Fee 38742	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,002.05 <b>Benefit:</b> 75% = \$1501.55	
<b>Amend</b> <b>Fee</b> 38745	Fee: \$2,002.05Benefit: 75% = \$1501.55INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)	

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC	
	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,221.00 <b>Benefit:</b> 75% = \$1665.75		
A	VENTRICULAR SEPTECTOMY, for congenital heart dis service to which item 11704, 11705, 11707, 11714, 18260, (Anaes.) (Assist.)		
<b>Amend</b> Fee 38748	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,221.00 Benefit: 75% = \$1665.75		
	Ventricular septal defect, closure by direct suture or patch, to which item 11704, 11705, 11707, 11714, 18260, 33824, (Assist.)		
<b>Amend</b> <b>Fee</b> 38751	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,221.00 Benefit: 75% = \$1665.75		
	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion a service associated with a service to which item 11704, 11 38806 or 45503 applies (H) (Anaes.) (Assist.)		
<b>Amend</b> <b>Fee</b> 38754	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,780.20 Benefit: 75% = \$2085.15		
	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38418, 38806 or 45503 applies (H) (Anaes.) (Assist.)		
<b>Amend</b> <b>Fee</b> 38757	(See para TN.8.67 of explanatory notes to this Category) Fee: $$2,221.00$ Benefit: $75\% = $1665.75$		
	EXTRACARDIAC CONDUIT, replacement of, for conger associated with a service to which item 11704, 11705, 1170 45503 applies (H) (Anaes.) (Assist.)		
<b>Amend</b> <b>Fee</b> 38760	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,221.00 <b>Benefit:</b> 75% = \$1665.75		
	VENTRICULAR AUGMENTATION, right or left, for con associated with a service to which item 11704, 11705, 1170 45503 applies (H) (Anaes.) (Assist.)		
Amend Fee 38766	d (See para TN.8.67 of explanatory notes to this Category) Fee: \$2,221.00 Benefit: 75% = \$1665.75		
	MISCELLANEOUS PROCEDUR	ES ON THE CHEST	
-	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies		
Fee 38800			
	THORACIC CAVITY, aspiration of, with therapeutic drain diagnostic sample	nage (paracentesis), with or without	
Fee 38803	<b>Fee:</b> \$80.00 <b>Benefit:</b> 75% = \$60.00 85% = \$68.00		
20002	INTERCOSTAL DRAIN, insertion of, not involving resec	tion of rib (excluding aftercare) (Anaes)	
<b>Fee</b> 38806	Fee: \$139.00         Benefit: 75% = \$104.25         85% = \$118.1		
Fee 38809	INTERCOSTAL DRAIN, insertion of, with pleurodesis an	d not involving resection of rib (excluding	

10. 301	RGICAL OPERAT	IONS	6. CARDIO-THORACIO		
	aftercare) (Anaes	s.)			
	Fee: \$171.25	<b>Benefit:</b> 75% = \$128.45	85% = \$145.60		
	PERCUTANEO	US NEEDLE BIOPSY of lu	ing (Anaes.)		
<b>Fee</b> 38812	Fee: \$217.65	<b>Benefit:</b> 75% = \$163.25	85% = \$185.05		
T8. SUF	RGICAL OPERAT	IONS	7. NEUROSURGICA		
	Group T8. Surgi	cal Operations			
		Sub	group 7. Neurosurgical		
			GENERAL		
Fee	LUMBAR PUN	CTURE (Anaes.)			
<b>3</b> 9000	Fee: \$78.35	<b>Benefit:</b> 75% = \$58.80	85% = \$66.60		
_		Procedure to obtain access to intracranial space (including subdural space, ventricle or basal cistern), percutaneously or by burr-hole (Anaes.)			
Fee 39007	Fee: \$165.90	<b>Benefit:</b> 75% = \$124.45	85% = \$141.05		
	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes.)				
<b>Fee</b> 39013	(See para TN.8.4 c <b>Fee:</b> \$113.55	of explanatory notes to this Cate Benefit: 75% = \$85.20			
	Intracranial paren care) (Anaes.)	nchymal pressure monitoring	g device, insertion of—including burr hole (excluding after		
<b>Fee</b> 39015	(See para TN.8.4, ' <b>Fee:</b> \$391.25	TN.8.166 of explanatory notes <b>Benefit:</b> 75% = \$293.45	to this Category)		
	Cerebrospinal re stereotaxy (Anae		r or external ventricular drain, insertion of, with or without		
<b>Fee</b> 39018	Fee: \$860.15	<b>Benefit:</b> 75% = \$645.15			
			PAIN RELIEF		
	INJECTION OF similar substance		TRIGEMINAL NERVE with alcohol, cortisone, phenol, or		
<b>Fee</b> 39100	(See para TN.8.4 c <b>Fee:</b> \$247.20	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$185.40			
	Trigeminal gangliotomy by radiofrequency, balloon or glycerol, including stereotaxy (Anaes.)		balloon or glycerol, including stereotaxy (Anaes.) (Assist.)		
		<b>Benefit:</b> 75% = \$1106.30	0 85% = \$1390.35		
	Fee: \$1,475.05	Cranial nerve, neurectomy or intracranial decompression of, using microsurgical techniques, including stereotaxy and cranioplasty (Anaes.) (Assist.)			
	Cranial nerve, ne				
Fee 39109 Fee 39113	Cranial nerve, ne		)		

T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL
	(Anaes.)	
	(See para TN.8.4 of explanatory notes to this Category)           Fee: \$78.35         Benefit: 75% = \$58.80         85% = \$66.60	
	PERCUTANEOUS NEUROTOMY for facet joint denervation using radiological imaging control (Anaes.) (Assist.)	n by radio-frequency probe or cryoprobe
<b>Fee</b> 39118	(See para TN.8.4 of explanatory notes to this Category)           Fee: \$309.90         Benefit: 75% = \$232.45         85% = \$263.45	
	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.)	
<b>Fee</b> 39121	(See para TN.8.4 of explanatory notes to this Category) <b>Fee:</b> \$657.35 <b>Benefit:</b> 75% = \$493.05 85% = \$572.65	
_	CORDOTOMY OR MYELOTOMY, partial or total laminect zone (Drez) lesion (Anaes.) (Assist.)	omy for, or operation for dorsal root entry
Fee 39124	<b>Fee:</b> \$1,682.30 <b>Benefit:</b> 75% = \$1261.75	
	Intrathecal or epidural SPINAL CATHETER insertion or repl subcutaneous implanted infusion pump, for the management of (Assist.)	
Fee 39125	<b>Fee:</b> \$310.10 <b>Benefit:</b> 75% = \$232.60	
	INFUSION PUMP, subcutaneous implantation or replacemen intrathecal or epidural catheter, and filling of reservoir with a without programming the pump, for the management of chron	therapeutic agent or agents, with or
Fee 39126	<b>Fee:</b> \$376.55 <b>Benefit:</b> 75% = \$282.45	
	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETE chronic intractable pain (Anaes.)	R, insertion of, for the management of
<b>Fee</b> 39127	(See para TN.8.4 of explanatory notes to this Category) <b>Fee:</b> \$492.85 <b>Benefit:</b> 75% = \$369.65	
	INFUSION PUMP, subcutaneous implantation of, AND intratinsertion of, and connection of pump to catheter, and filling of agents, with or without programming the pump, for the manag (Assist.)	f reservoir with a therapeutic agent or
Fee 39128	<b>Fee:</b> \$686.65 <b>Benefit:</b> 75% = \$515.00	
	EPIDURAL LEAD, percutaneous placement of, including intr management of chronic intractable neuropathic pain or pain fr maximum of 4 leads (Anaes.)	
<b>Fee</b> 39130	(See para TN.8.4 of explanatory notes to this Category) <b>Fee:</b> \$701.45 <b>Benefit:</b> 75% = \$526.10	
	ELECTRODES, epidural or peripheral nerve, management of of neurostimulator by a medical practitioner, for the managem or pain from refractory angina pectoris - each day	
Fee 39131	<b>Fee:</b> \$133.00 <b>Benefit:</b> 75% = \$99.75 85% = \$113.05	
<b>Fee</b> 39133	Removal of subcutaneously IMPLANTED INFUSION PUMF intrathecal or epidural SPINAL CATHETER, for the manager	

T8. SUR	GICAL OPERAT	IONS	7. NEUROSURGICAL	
	(See para TN.8.4 c <b>Fee:</b> \$165.90	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$124.45		
Fee	connection of ex		ous placement of, including placement and ral nerve electrodes, for the management of chronic angina pectoris (Anaes.) (Assist.)	
<b>Fee</b> 39134	Fee: \$354.40	<b>Benefit:</b> 75% = \$265.80		
		or pain from refractory angina pec	serted for the management of chronic intractable toris, removal of, performed in the operating theatre	
Fee 39135	Fee: \$165.90	<b>Benefit:</b> 75% = \$124.45		
		or pain from refractory angina pec	d for the management of chronic intractable toris, removal of, performed in the operating theatre	
<b>Fee</b> 39136	(See para TN.8.4 c <b>Fee:</b> \$165.90	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$124.45		
	neuropathic pain or unsatisfactory	or pain from refractory angina pec	d for the management of chronic intractable toris, surgical repositioning to correct displacement we test stimulation, not being a service to which item	
Fee 39137	Fee: \$629.90	<b>Benefit:</b> 75% = \$472.45		
	PERIPHERAL NERVE LEAD, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) (Assist.)			
Fee 39138	Fee: \$701.45	<b>Benefit:</b> 75% = \$526.10		
_	intraoperative te		partial or total laminectomy, including of chronic intractable neuropathic pain or pain from s (H) (Anaes.) (Assist.)	
Fee 39139	Fee: \$941.80	<b>Benefit:</b> 75% = \$706.35		
_		THETER, insertion of, under imagi tion for lysis of adhesions (Anaes.)	ng control, with epidurogram and epidural	
Fee 39140	Fee: \$304.70	<b>Benefit:</b> 75% = \$228.55 85% =	= \$259.00	
	PERIPHERAL NERVES			
Amend Fee	end Nerve, digital or cutaneous, primary repair of, using microsurgical techniques, other than a sassociated with a service to which item 39330 applies—applicable once per nerve (H) (Anat			
39300	Fee: \$367.70	<b>Benefit:</b> 75% = \$275.80		
	Nerve, digital or cutaneous, delayed repair of, using microsurgical techniques, including either or both of the following (if performed):			
	(a) neurolysis;			
Amend	(b) transposition	of nerve to facilitate repair;		
Fee 39303	other than a serv	ice associated with a service to whi	ch item 30023 applies—applicable once per nerve	

T8. SUR	GICAL OPERATIO	ONS	7. NEUROSURGICAL	
	(H) (Anaes.) (Assi	st.)		
	Fee: \$485.00	<b>Benefit:</b> 75% = \$363.75		
Amend Fee	Nerve trunk, primary repair of, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.)			
39306	<b>Fee:</b> \$704.25 <b>Benefit:</b> 75% = \$528.20			
NT	Reconstruction of nerve trunk using biological or synthetic nerve conduit, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (Anaes.) (Assist.)			
<b>New</b> 39307	Fee: \$857.55	<b>Benefit:</b> 75% = \$643.20 85% = \$772	.85	
	Nerve trunk, delay (if performed):	ed repair of, using microsurgical techni	iques, including either or both of the following	
	(a) neurolysis;			
	(b) transposition o	f nerve or nerve transfer to facilitate rep	pair;	
Amend Fee	other than a servic (Assist.)	e associated with a service to which ite	m 30023 or 39321 applies (H) (Anaes.)	
39309	Fee: \$743.35	<b>Benefit:</b> 75% = \$557.55		
Amend Fee	end Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques, other associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)			
39312	Fee: \$418.45	<b>Benefit:</b> 75% = \$313.85		
	Nerve trunk, nerve graft to, by cable graft, using microsurgical techniques, including any of the following (if performed):			
	(a) harvesting of nerve graft;			
	(b) proximal and distal anastomosis of nerve graft;			
	(c) transposition of nerve to facilitate grafting;			
	(d) neurolysis;			
Amend Fee	other than a service associated with a service to which item 30023 or 39330 applies (H) (Anaes.) (Assist.)			
<b>593</b> 15	Fee: \$1,071.95	<b>Benefit:</b> 75% = \$804.00		
	Nerve, digital or cutaneous, nerve graft to, using microsurgical techniques, including either or both of the following (if performed):			
	(a) harvesting of nerve graft from separate donor site;			
	(b) proximal and distal anastomosis of nerve graft;			
Amend Fee	other than a servic	e associated with a service to which iter	m 39330 applies (H) (Anaes.) (Assist.)	
39318	Fee: \$665.15	<b>Benefit:</b> 75% = \$498.90		
<b>New</b> 39319		digital or cutaneous nerve using biolog niques, other than a service associated	ical or synthetic nerve conduit, using with a service to which item 39330 applies	

T8. SUR	GICAL OPERATIONS 7. NEUROSURG	ICAL	
	(Anaes.) (Assist.)		
	<b>Fee:</b> \$485.00 <b>Benefit:</b> 75% = \$363.75 85% = \$412.25		
	NERVE, transposition of (Anaes.) (Assist.)		
Fee 39321	<b>Fee:</b> \$492.85 <b>Benefit:</b> 75% = \$369.65		
	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a	l	
Fee	service to which another item applies (Anaes.) (Assist.)		
39323	Fee: \$288.00         Benefit: 75% = \$216.00         85% = \$244.80		
	Neurectomy or removal of tumour or neuroma from superficial peripheral nerve (Anaes.) (Assist.)		
Amend Fee 39324	(See para TN.8.4 of explanatory notes to this Category) <b>Fee:</b> \$288.00 <b>Benefit:</b> 75% = \$216.00 85% = \$244.80		
	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral or cranial nerve, by o operation, not being a service to which item 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist		
<b>Fee</b> 39327	(See para TN.8.4 of explanatory notes to this Category) <b>Fee:</b> \$492.95 <b>Benefit:</b> 75% = \$369.75		
	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve, by open operation, for u limb surgery (H) (Anaes.) (Assist.)	pper	
New 39328	<b>Fee:</b> \$492.95 <b>Benefit:</b> 75% = \$369.75		
Nam	Extensive neurolysis of radial, median or ulnar nerve trunk nerve in the forearm or arm, other than a service associated with a service to which item 30023, 39303, 39309, 39312, 39315, 39318, 39324, 39327 or 39333 applies (Anaes.) (Assist.)		
New 39329	<b>Fee:</b> \$367.70 <b>Benefit:</b> 75% = \$275.80 85% = \$312.55		
	Neurolysis by open operation without transposition, other than a service associated with a service to which item 30023, 39321, 39328, 39329, 39332, 39336, 39339, 39342, 39345, 49774 or 49775 app (H)		
Amend Fee	(Anaes.) (Assist.)		
39330	<b>Fee:</b> \$288.00 <b>Benefit:</b> 75% = \$216.00		
	Carpal tunnel release, including division of transverse carpal ligament or release of median nerve, b method, including either or both of the following (if performed):	y any	
	(a) synovectomy;		
	(b) neurolysis		
Amend Fee	Other than a service associated with a service to which item 30023 or 46339 applies (Anaes.) (Assist	st.)	
39331	Fee:         \$288.00         Benefit:         75% = \$216.00         85% = \$244.80		
<b>New</b> 39332	Revision of carpal tunnel release, including division of transverse carpal ligament or release of med nerve, by any method, including either or both of the following (if performed):	lian	

T8. SUF		DNS 7. NEUROSURGICAL	
	(a) synovectomy		
	(b) neurolysis;		
	other than a servi	e associated with a service to which item 30023 or 46339 applies. (Anaes.) (Assist.)	
	Fee: \$432.05	<b>Benefit:</b> 75% = \$324.05 85% = \$367.25	
	BRACHIAL PLE (Anaes.) (Assist.)	KUS, exploration of, not being a service to which another item in this Group applies	
Fee 39333	Fee: \$414.70	<b>Benefit:</b> 75% = \$311.05 85% = \$352.50	
	any method, inclu	npression at elbow or wrist (cubital tunnel or Guyon's canal) without transposition, by ding neurolysis (if performed), other than a service associated with a service to which s (Anaes.) (Assist.)	
New 39336	Fee: \$288.00	<b>Benefit:</b> 75% = \$216.00 85% = \$244.80	
New		herve decompression at elbow (cubital tunnel) without transposition, by any method, is (if performed), other than a service associated with a service to which item 30023 Assist.)	
39339	Fee: \$432.05	<b>Benefit:</b> 75% = \$324.05 85% = \$367.25	
	Ulnar nerve deco	pression at elbow (cubital tunnel), including any of the following (if performed):	
	(a) associated transposition;		
	(b) subcutaneous or submuscular transposition of the nerve;		
	(c) medial epicondylectomy;		
	(d) ostetomy and reconstruction of the flexor origin;		
	(e) neurolysis;		
New	other than a servi	e associated with a service to which item 30023 applies (Anaes.) (Assist.)	
39342	Fee: \$566.75	<b>Benefit:</b> 75% = \$425.10 85% = \$482.05	
N	compressive neur	ression of radial, median or ulnar nerve, or branches of, in the forearm for pathy, including neurolysis (if performed), other than a service associated with a em 30023 applies (Anaes.) (Assist.)	
<b>New</b> 39345	Fee: \$288.00	<b>Benefit:</b> 75% = \$216.00 85% = \$244.80	
	CRANIAL NERVES		
	Facio-hypoglossal nerve or facio-accessory nerve, anastomosis of (Anaes.) (Assist.)		
<b>Fee</b> 39503	(See para TN.8.166 <b>Fee:</b> \$993.70	of explanatory notes to this Category) Benefit: 75% = \$745.30	
	CRANIO-CEREBRAL INJURIES		
	Any of the follow	ng procedures for intracranial haemorrhage or swelling:	
Fee	stereotaxy; (b) craniotomy	craniectomy or burr-holes for removal of intracranial haemorrhage, including or craniectomy for brain swelling, stroke, or raised intracranial pressure, including for	
39604	subtemporal deco	npression, including stereotaxy; or	

T8. SUF	GICAL OPERATIONS	7. NEUROSURGICAL
	(c) post-operative re-opening, including (Anaes.) (Assist.)	g for swelling or post-operative cerebrospinal fluid leak.
	<b>Fee:</b> \$1,866.25 <b>Benefit:</b> 75% = \$139	9.70
	Fractured skull, without brain laceration of	or dural penetration, repair of (Anaes.) (Assist.)
Fee 39610	<b>Fee:</b> \$993.70 <b>Benefit:</b> 75% = \$745	.30
	Fractured skull, with brain laceration or d otorrhoea, repair of (Anaes.) (Assist.)	ural penetration but without cerebrospinal fluid, rhinorrhoea or
Fee 39612	<b>Fee:</b> \$1,165.90 <b>Benefit:</b> 75% = \$874	.45
	Fractured skull, after trauma, with cerebro stereotaxy and dermofat graft (Anaes.) (A	ospinal fluid rhinorrhoea or otorrhoea, repair of, including
Fee 39615	<b>Fee:</b> \$1,989.50 <b>Benefit:</b> 75% = \$149	2.15
		KULL BASE SURGERY
		nous sinus, tumour or vascular lesion, removal or radical nioplasty—conjoint surgery, principal surgeon (Anaes.)
<b>Fee</b> 39638	(See para TN.8.70 of explanatory notes to this <b>Fee:</b> \$4,429.65 <b>Benefit:</b> 75% = \$332	
		nous sinus, tumour or vascular lesion, removal or radical ioplasty—conjoint surgery, co-surgeon (Assist.)
<b>Fee</b> 39639	(See para TN.8.70 of explanatory notes to this <b>Fee:</b> \$3,539.75 <b>Benefit:</b> 75% = \$265	
	Anterior or middle cranial fossa or caverr excision of, including stereotaxy and crar	nous sinus, tumour or vascular lesion, removal or radical hioplasty - one surgeon (Anaes.) (Assist.)
<b>Fee</b> 39641	(See para TN.8.70 of explanatory notes to this <b>Fee:</b> \$4,672.15 <b>Benefit:</b> 75% = \$350	
	Petro-clival, clival or foramen magnum to including stereotaxy and cranioplasty - or	mour or vascular lesion, removal or radical excision of, ne surgeon (Anaes.) (Assist.)
<b>Fee</b> 39651	(See para TN.8.70 of explanatory notes to this <b>Fee:</b> \$5,764.25 <b>Benefit:</b> 75% = \$432	
		amour or vascular lesion, removal or radical excision of, onjoint surgery, principal surgeon (Anaes.) (Assist.)
<b>Fee</b> 39654	(See para TN.8.70 of explanatory notes to this <b>Fee:</b> \$4,429.65 <b>Benefit:</b> 75% = \$332	
	Petro clival, clival or foramen magnum tu including stereotaxy and cranioplasty—co	mour or vascular lesion, removal or radical excision of, onjoint surgery, co surgeon (Assist.)
<b>Fee</b> 39656	(See para TN.8.70 of explanatory notes to this <b>Fee:</b> \$3,539.75 <b>Benefit:</b> 75% = \$265	
	INTR	A-CRANIAL NEOPLASMS
<b>F</b>	Skull tumour, benign or malignant, excisi	on of, including stereotaxy and cranioplasty (Anaes.) (Assist.)
Fee 39700	<b>Fee:</b> \$1,885.80 <b>Benefit:</b> 75% = \$141	4.35

T8. SUF		ONS	7. NEUROSURGICAL
	<ul><li>(a) burr hole and b</li><li>(b) drainage of;</li></ul>	ir, cyst or other brain tissue, either biopsy of; xy (Anaes.) (Assist.)	or both of:
Fee 39703	<b>Fee:</b> \$1,514.20	<b>Benefit:</b> 75% = \$1135.65	
39703	-		ecompression or removal of, through a single
<b>Fee</b> 39710		ding stereotaxy and cranioplasty (A Benefit: 75% = \$1891.20	
Fac	<ul> <li>(a) meningioma;</li> <li>(b) pinealoma;</li> <li>(c) cranio pharyng</li> <li>(d) pituitary tumo</li> <li>(e) intraventricula</li> <li>(f) brain stem lesid</li> <li>(g) any other intra</li> </ul>	ur; r lesion; on; cranial tumour; th or without endoscopy), through a	e of any of the following:
Fee 39712	Fee: \$3,851.65	<b>Benefit:</b> 75% = \$2888.75	
Fee	fascia grafting, otl (Assist.)	her than a service associated with a	bach, including stereotaxy and dermis, dermofat or service to which item 40600 applies (Anaes.)
39715	Fee: \$2,811.05	<b>Benefit:</b> 75% = \$2108.30	
<b>Fee</b> 39718	Arachnoidal cyst, Fee: \$1,698.05	Benefit: 75% = \$1273.55	xy and neuroendoscopy (Anaes.) (Assist.)
-	Awake craniotom	y for functional neurosurgery (Ana	es.) (Assist.)
Fee 39720	Fee: \$3,603.20	<b>Benefit:</b> 75% = \$2702.40	
		CEREBROVASC	ULAR DISEASE
_	Aneurysm, clippir (Anaes.) (Assist.)	ng, proximal ligation, or reinforcem	ent of sac, including stereotaxy and cranioplasty
Fee 39801	Fee: \$5,764.25	<b>Benefit:</b> 75% = \$4323.20	
5		ovenous malformation or fistula, tre ll angiography (Anaes.) (Assist.)	eatment through a craniotomy, including stereotaxy,
Fee 39803	Fee: \$5,764.25	<b>Benefit:</b> 75% = \$4323.20	
	CAROTID-CAVE (Anaes.) (Assist.)	ERNOUS FISTULA, obliteration o	f - combined cervical and intracranial procedure
Fee 39815	Fee: \$1,901.30	<b>Benefit:</b> 75% = \$1426.00 85% =	\$1816.60
			s, including stereotaxy (Anaes.) (Assist.)
<b>Fee</b> 39818	Fee: \$2,523.45	<b>Benefit:</b> 75% = \$1892.60	
<b>Fee</b> 39821	· · ·		techniques, including stereotaxy (Anaes.) (Assist.)

T8. SUR	GICAL OPERATIO	INS	7. NEUROSURGICAL	
	Fee: \$3,595.40	<b>Benefit:</b> 75% = \$2696.55		
	Ventricular, lumba (Assist.)	r or cisternal shunt diversion, insertion or r	revision of, including stereotaxy (Anaes.)	
Fee 40004	Fee: \$1,721.50	<b>Benefit:</b> 75% = \$1291.15		
		INFECTION		
_		on, treated by burr hole, including stereotar em 40600 applies (Anaes.) (Assist.)	xy, other than a service associated with a	
Fee 39900	Fee: \$1,514.20	<b>Benefit:</b> 75% = \$1135.65		
Fee		on, treated by craniotomy, including stereo em 40600 applies (Anaes.) (Assist.)	taxy, other than a service associated with a	
<b>5</b> 9903	Fee: \$2,273.20	<b>Benefit:</b> 75% = \$1704.90		
		cull or removal of infected bone flap, crani hich item 40600 applies (Anaes.) (Assist.)	ectomy for, other than a service associated	
<b>Fee</b> 39906	(See para TN.8.166 ( <b>Fee:</b> \$829.40	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$622.05		
		CEREBROSPINAL FLUID CIRCULA	TION DISORDERS	
_	Endoscopic ventric stereotaxy (Anaes.	culostomy for treatment of cerebrospinal flue) (Assist.)	uid circulation disorders, including	
Fee 40012	Fee: \$1,780.20	<b>Benefit:</b> 75% = \$1335.15		
		BROSPINAL FLUID DRAIN, insertion of	(Anaes.)	
<b>Fee</b> 40018	Fee: \$165.90	<b>Benefit:</b> 75% = \$124.45 85% = \$141.05	、	
	CONGENITAL DISORDERS			
	Spinal myelomeningocele or spinal meningocele, excision and closure of, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)			
<b>Fee</b> 40104	(See para TN.8.166 of explanatory notes to this Category) <b>Fee:</b> \$1,056.35 <b>Benefit:</b> 75% = \$792.30			
		on, decompression or reconstruction of, inc aan a service associated with a service to w		
Fee 40106	Fee: \$2,507.80	<b>Benefit:</b> 75% = \$1880.85		
	Encephalocoele or cranial meningocele, excision and closure of, including stereotaxy and dermofat gra (Anaes.) (Assist.)		of, including stereotaxy and dermofat graft	
Fee 40109	Fee: \$1,946.40	<b>Benefit:</b> 75% = \$1459.80		
	Tethered cord, release of, including lipomeningocele or diastematomyelia, multiple levels, including laminectomy and rhizolysis, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)			
Fee 40112	Fee: \$2,486.35	<b>Benefit:</b> 75% = \$1864.80		
			with a service to which item 40600 applies	
Fee 40119	<b>Fee:</b> \$993.70	<b>Benefit:</b> 75% = \$745.30		

T8. SUR	RGICAL OPERATIONS 7. NEUROSURGICAL
	SKULL RECONSTRUCTION
_	Cranioplasty, reconstructive, other than a service associated with a service to which item 39113, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39710, 39712, 39715, 39801, 39803 or 40703 applies (Anaes.) (Assist.)
Fee 40600	<b>Fee:</b> \$993.70 <b>Benefit:</b> 75% = \$745.30
	EPILEPSY
_	Corpus callosotomy, for epilepsy, including stereotaxy (Anaes.) (Assist.)
Fee 40700	<b>Fee:</b> \$2,437.45 <b>Benefit:</b> 75% = \$1828.10
	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
Fee	(b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)
40701	Fee: \$354.40         Benefit: 75% = \$265.80
	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of electrical pulse generator inserted for:
	(a) management of refractory generalised epilepsy; or
T.	(b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)
Fee 40702	<b>Fee:</b> \$165.90 <b>Benefit:</b> 75% = \$124.45
_	Corticectomy, topectomy or partial lobectomy, for epilepsy, including stereotaxy and cranioplasty (Anaes.) (Assist.)
Fee 40703	<b>Fee:</b> \$2,521.60 <b>Benefit:</b> 75% = \$1891.20
	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical placement of lead, including connection of lead to left vagus nerve and intra-operative test stimulation, for:
	(a) management of refractory generalised epilepsy; or
	(b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)
Fee	
40704	Fee:     \$701.45     Benefit:     75% = \$526.10
	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 resective epilepsy surgery (Anaes.) (Assist.)
Fee 40705	<b>Fee:</b> \$629.90 <b>Benefit:</b> 75% = \$472.45
	Hemispherectomy or functional hemispherectomy, for intractable epilepsy, including stereotaxy (Anaes.) (Assist.)
<b>Fee</b> 40706	<b>Fee:</b> \$3,603.25 <b>Benefit:</b> 75% = \$2702.45
<b>Fee</b> 40707	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, electrical analysis and

T8. SUF	GICAL OPERATI	ONS	7. NEUROSU	RGICAL
	programming of v	vagus nerve stimulation the	herapy device using external wand, for:	
	(a) management of	of refractory generalised ep	epilepsy; or	
	(b) treatment of re	efractory focal epilepsy no	ot suitable for resective epilepsy surgery	
	Fee: \$197.40	<b>Benefit:</b> 75% = \$148.05	85% = \$167.80	
		ulation therapy through sti cal pulse generator inserted	timulation of the left vagus nerve, surgical replacement d for:	nt of
	(a) management of	of refractory generalised ep	epilepsy; or	
Fee	(b) treating refrac	ctory focal epilepsy not sui	nitable for resective epilepsy surgery (Anaes.) (Assist.)	)
40708	Fee: \$354.40	<b>Benefit:</b> 75% = \$265.80	30	
<b>.</b>	Intracranial electr	rode placement by burr hol	ole, including stereotaxy (Anaes.) (Assist.)	
Fee 40709	Fee: \$1,514.20	<b>Benefit:</b> 75% = \$1135.6	.65	
	Intracranial electr stereotaxy (Anaes		tomy, single or multiple, including stereotactic EEG, i	ncluding
Fee 40712	Fee: \$3,603.25	<b>Benefit:</b> 75% = \$2702.4	.45	
		STERE	EOTACTIC PROCEDURES	
Fee	localisation, and l tracts, other than tremor or dystoni	lesion production, by any r a service associated with d a (Anaes.) (Assist.)	g computer assisted anatomical localisation, physiolog method, in the basal ganglia, brain stem or deep whit deep brain stimulation for Parkinson's disease, essent	e matter
40801	Fee: \$1,816.55	<b>Benefit:</b> 75% = \$1362.4		
	Intracranial stered	otactic procedure by any m	method, other than:	
	(a) a service to w	hich item 40801 applies; o	or	
	39641, 39651, 39	9654, 39656, 39700, 39703 9903, 40004, 40012, 40106	hich item 39018, 39109, 39113, 39604, 39615, 39638 3, 39710, 39712, 39715, 39718, 39720, 39801, 39803 6, 40109, 40700, 40703, 40706, 40709 or 40712 appli	, 39818,
<b>Fee</b> 40803	(See para TN.8.166 <b>Fee:</b> \$1,244.15	5 of explanatory notes to this $G$ <b>Benefit:</b> 75% = \$933.15		
	assisted anatomic		<ol> <li>functional stereotactic procedure including compute ical localisation including twist drill, burr hole cranio r the treatment of:</li> </ol>	
		se where the patient's response motor fluctuations; or	ponse to medical therapy is not sustained and is accon	npanied
Foo	Essential tremor of	or dystonia where the patie	ient's symptoms cause severe disability (Anaes.) (Assi	ist.)
<b>Fee</b> 40850	Fee: \$2,356.20	<b>Benefit:</b> 75% = \$1767.1	.15	
Fee	DEEP BRAIN ST	FIMULATION (bilateral)	) functional stereotactic procedure including computer	assisted

T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL
40851	anatomical localisation, physiological localisation including twist dri craniectomy and insertion of electrodes for the treatment of:	ll, burr hole craniotomy or
	Parkinson's disease where the patient's response to medical therapy is by unacceptable motor fluctuations; or	s not sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause seve	ere disability. (Anaes.) (Assist.)
	<b>Fee:</b> \$4,123.60 <b>Benefit:</b> 75% = \$3092.70	
	DEEP BRAIN STIMULATION (unilateral) subcutaneous placement pulse generator for the treatment of:	of neurostimulator receiver or
	Parkinson's disease where the patient's response to medical therapy is by unacceptable motor fluctuations; or	s not sustained and is accompanied
Fee	Essential tremor or dystonia where the patient's symptoms cause seve	ere disability. (Anaes.) (Assist.)
40852	Fee: \$354.40Benefit: 75% = \$265.80DEEP BRAIN STIMULATION (unilateral) revision or removal of b	
	Parkinson's disease where the patient's response to medical therapy is by unacceptable motor fluctuations; or	s not sustained and is accompanied
Fee	Essential tremor or dystonia where the patient's symptoms cause seve	ere disability. (Anaes.)
40854	<b>Fee:</b> \$547.70 <b>Benefit:</b> 75% = \$410.80	
	DEEP BRAIN STIMULATION (unilateral) removal or replacement generator for the treatment of:	of neurostimulator receiver or pulse
	Parkinson's disease where the patient's response to medical therapy is by unacceptable motor fluctuations; or	s not sustained and is accompanied
Fee	Essential tremor or dystonia where the patient's symptoms cause seve	ere disability. (Anaes.)
40856	<b>Fee:</b> \$265.80 <b>Benefit:</b> 75% = \$199.35	
	DEEP BRAIN STIMULATION (unilateral) placement, removal or rethe treatment of:	eplacement of extension lead for
	Parkinson's disease where the patient's response to medical therapy is by unacceptable motor fluctuations; or	s not sustained and is accompanied
Fee	Essential tremor or dystonia where the patient's symptoms cause seve	ere disability. (Anaes.)
40858	<b>Fee:</b> \$547.70 <b>Benefit:</b> 75% = \$410.80	
Fee 40860	DEEP BRAIN STIMULATION (unilateral) target localisation incorp	porating anatomical and

T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL
	physiological techniques, including intra-operative clinical evaluat neurostimulation wire for the treatment of:	tion, for the insertion of a single
	Parkinson's disease where the patient's response to medical therapy by unacceptable motor fluctuations; or	y is not sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause set	evere disability. (Anaes.)
	<b>Fee:</b> \$2,104.65 <b>Benefit:</b> 75% = \$1578.50	
	DEEP BRAIN STIMULATION (unilateral) electronic analysis and pulse generator for the treatment of:	d programming of neurostimulator
	Parkinson's disease where the patient's response to medical therapy by unacceptable motor fluctuations; or	y is not sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause set	evere disability. (Anaes.)
<b>Fee</b> 40862	<b>Fee:</b> \$197.40 <b>Benefit:</b> 75% = \$148.05 85% = \$167.80	
	MISCELLANEOUS	
<b>Fee</b> 40905	Craniotomy, performed by a neurosurgeon in conjunction with the abnormalities (Anaes.) (Assist.) Fee: \$626.10 Benefit: 75% = \$469.60	correction of craniofacial
	<b>Fee.</b> $\phi_{20.10}$ <b>Deneme.</b> $75\% - \phi_{4}05.00$	
T8. SUF	RGICAL OPERATIONS	8. EAR, NOSE AND THROAT
T8. SUF	RGICAL OPERATIONS Group T8. Surgical Operations	8. EAR, NOSE AND THROAT
T8. SUF		· · · · · · · · · · · · · · · · · · ·
T8. SUF	Group T8. Surgical Operations	hroat
<b>Fee</b> 41500	Group T8. Surgical Operations Subgroup 8. Ear, Nose And T	hroat
Fee	Group T8. Surgical Operations Subgroup 8. Ear, Nose And T EAR, foreign body (other than ventilating tube) in, removal of, oth (See para TN.8.72 of explanatory notes to this Category)	hroat her than by simple syringing (Anaes.) rocal folds by a specialist in the ostroboscopy, including capturing is , or for confirmation of treatment
Fee	Group T8. Surgical Operations         Subgroup 8. Ear, Nose And TI         EAR, foreign body (other than ventilating tube) in, removal of, oth         (See para TN.8.72 of explanatory notes to this Category)         Fee: \$85.80       Benefit: 75% = \$64.35         Examination of glottal cycles and vibratory characteristics of the v         practice of the specialist's specialty of otolaryngology using video         audio, video, frequency and intensity, for confirmation of diagnosi         effectiveness where there is failure to progress or respond as expect         a.       dysphonia where non stroboscopic techniques of the visue identify any frank abnormality of the vocal folds; or	hroat her than by simple syringing (Anaes.) rocal folds by a specialist in the ostroboscopy, including capturing is , or for confirmation of treatment cted, for:
Fee	Group T8. Surgical Operations         Subgroup 8. Ear, Nose And TI         EAR, foreign body (other than ventilating tube) in, removal of, oth         (See para TN.8.72 of explanatory notes to this Category)         Fee: \$85.80       Benefit: 75% = \$64.35         Examination of glottal cycles and vibratory characteristics of the v         practice of the specialist's specialty of otolaryngology using video         audio, video, frequency and intensity, for confirmation of diagnosi         effectiveness where there is failure to progress or respond as expect         a. dysphonia where non stroboscopic techniques of the visue         identify any frank abnormality of the vocal folds; or         b. benign or malignant vocal fold lesions; or	hroat her than by simple syringing (Anaes.) rocal folds by a specialist in the ostroboscopy, including capturing is , or for confirmation of treatment cted, for:
Fee	Group T8. Surgical Operations         Subgroup 8. Ear, Nose And T         EAR, foreign body (other than ventilating tube) in, removal of, oth         (See para TN.8.72 of explanatory notes to this Category)         Fee: \$85.80       Benefit: 75% = \$64.35         Examination of glottal cycles and vibratory characteristics of the v         practice of the specialist's specialty of otolaryngology using video audio, video, frequency and intensity, for confirmation of diagnost effectiveness where there is failure to progress or respond as expect         a. dysphonia where non stroboscopic techniques of the visue identify any frank abnormality of the vocal folds; or         b. benign or malignant vocal fold lesions; or	hroat her than by simple syringing (Anaes.) rocal folds by a specialist in the estroboscopy, including capturing is , or for confirmation of treatment cted, for: alising the larynx have failed to
Fee	Group T8. Surgical Operations         Subgroup 8. Ear, Nose And TI         EAR, foreign body (other than ventilating tube) in, removal of, oth         (See para TN.8.72 of explanatory notes to this Category)         Fee: \$85.80       Benefit: 75% = \$64.35         Examination of glottal cycles and vibratory characteristics of the v         practice of the specialist's specialty of otolaryngology using video         audio, video, frequency and intensity, for confirmation of diagnosi         effectiveness where there is failure to progress or respond as expect         a. dysphonia where non stroboscopic techniques of the visu-         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	hroat her than by simple syringing (Anaes.) rocal folds by a specialist in the ostroboscopy, including capturing is , or for confirmation of treatment cted, for: alising the larynx have failed to
Fee	Group T8. Surgical Operations         Subgroup 8. Ear, Nose And T         EAR, foreign body (other than ventilating tube) in, removal of, oth         (See para TN.8.72 of explanatory notes to this Category)         Fee: \$85.80       Benefit: 75% = \$64.35         Examination of glottal cycles and vibratory characteristics of the v         practice of the specialist's specialty of otolaryngology using video         audio, video, frequency and intensity, for confirmation of diagnosi         effectiveness where there is failure to progress or respond as expect         a. dysphonia where non stroboscopic techniques of the visu-         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 phono         other than a service associated with a service to which item 41764	hroat her than by simple syringing (Anaes.) rocal folds by a specialist in the ostroboscopy, including capturing is , or for confirmation of treatment cted, for: alising the larynx have failed to

T8. SUF		ONS 8. EAR, NOSE AND THROAT
	EAR, foreign bod	y in, removal of, involving incision of external auditory canal (Anaes.)
Fee 41503	Fee: \$248.45	<b>Benefit:</b> 75% = \$186.35 85% = \$211.20
-	AURAL POLYP,	removal of (Anaes.)
Fee 41506	Fee: \$149.85	<b>Benefit:</b> 75% = \$112.40 85% = \$127.40
		DITORY MEATUS, surgical removal of keratosis obturans from, not being a service
Fee	to which another i	item in this Group applies (Anaes.)
41509	Fee: \$169.55	<b>Benefit:</b> 75% = \$127.20 85% = \$144.15
		involving removal of cartilage or bone or both cartilage and bone, not being a service (15 applies (Anaes.) (Assist.)
Fee		
41512	Fee: \$609.65	<b>Benefit:</b> 75% = \$457.25
		involving removal of cartilage or bone or both cartilage and bone, being a service service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assist.)
<b>Fee</b> 41515	(See para TN.8.73 c <b>Fee:</b> \$400.10	of explanatory notes to this Category) Benefit: 75% = \$300.10
-	EXTERNAL AU	DITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.)
Fee 41518	Fee: \$966.35	<b>Benefit:</b> 75% = \$724.80
	Correction of AU (Anaes.) (Assist.)	DITORY CANAL STENOSIS, including meatoplasty, with or without grafting
Fee 41521	Fee: \$1,028.90	<b>Benefit:</b> 75% = \$771.70
		ION OF EXTERNAL AUDITORY CANAL, being a service associated with a service 557, 41560 and 41563 apply (Anaes.) (Assist.)
<b>Fee</b> 41524	(See para TN.8.74 c <b>Fee:</b> \$297.25	of explanatory notes to this Category) Benefit: 75% = \$222.95
	MYRINGOPLAS	TY, transcanal approach (Rosen incision) (Anaes.) (Assist.)
Fee 41527	<b>Fee:</b> \$611.40	<b>Benefit:</b> 75% = \$458.55
	MYRINGOPLAS	TY, postaural or endaural approach with or without mastoid inspection (Anaes.)
Fee 41530	<b>Fee:</b> \$996.10	<b>Benefit:</b> 75% = \$747.10
		vithout reconstruction of the bony defect, with or without myringoplasty (Anaes.)
<b>F</b>	(Assist.)	
<b>Fee</b> 41533	Fee: \$1,190.65	<b>Benefit:</b> 75% = \$893.00
	ATTICOTOMY v	with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.)
Fee 41536	Fee: \$1,333.65	<b>Benefit:</b> 75% = \$1000.25
	OSSICULAR CH	AIN RECONSTRUCTION (Anaes.) (Assist.)
Fee 41539	Fee: \$1,134.05	<b>Benefit:</b> 75% = \$850.55
		AIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.)
Fee 41542	Fee: \$1,242.65	<b>Benefit:</b> 75% = \$932.00

T8. SUF	GICAL OPERATI	ONS	8. EAR, NOSE AND THROAT
	MASTOIDECTO	MY (CORTICAL) (Anaes.) (As	sist.)
Fee 41545	Fee: \$542.40	<b>Benefit:</b> 75% = \$406.80	
	OBLITERATION	NOF THE MASTOID CAVITY	(Anaes.) (Assist.)
Fee 41548	<b>Fee:</b> \$719.75	<b>Benefit:</b> 75% = \$539.85	
110.10			myringoplasty (Anaes.) (Assist.)
Fee		-	
41551	<b>Fee:</b> \$1,657.65	<b>Benefit:</b> 75% = \$1243.25	myringoplasty and ossicular chain reconstruction
	(Anaes.) (Assist.)	· · · · ·	myringoplasty and ossicular chain reconstruction
Fee 41554	Fee: \$1,953.00	<b>Benefit:</b> 75% = \$1464.75	
11334			D RADICAL) (Anaes.) (Assist.)
Fee			
41557	<b>Fee:</b> \$1,134.05	<b>Benefit:</b> 75% = \$850.55	
Fee	MASTOIDECTO	MY (RADICAL OR MODIFIE	D RADICAL) AND MYRINGOPLASTY (Anaes.)
41560	Fee: \$1,242.65	<b>Benefit:</b> 75% = \$932.00	
		MY (RADICAL OR MODIFIE IAIN RECONSTRUCTION (Ar	D RADICAL), MYRINGOPLASTY AND aes.) (Assist.)
<b>Fee</b> 41563	Fee: \$1,538.30	<b>Benefit:</b> 75% = \$1153.75	
	CAVITY, BLINE		D RADICAL), OBLITERATION OF THE MASTOID AL AUDITORY CANAL AND OBLITERATION
Fee			
41564	Fee: \$1,989.30	<b>Benefit:</b> 75% = \$1492.00	
-	REVISION OF M (Anaes.) (Assist.)		odified radical or intact wall), including myringoplasty
Fee 41566	Fee: \$1,134.05	<b>Benefit:</b> 75% = \$850.55	
	DECOMPRESSI	ON OF FACIAL NERVE in its	mastoid portion (Anaes.) (Assist.)
Fee 41569	Fee: \$1,242.65	<b>Benefit:</b> 75% = \$932.00	
41309			LABYRINTH (Anaes.) (Assist.)
Fee			
41572	Fee: \$1,075.10	<b>Benefit:</b> 75% = \$806.35	
	transmastoid, tran		emoval of by 2 surgeons operating conjointly, by proach transmastoid, translabyrinthine or retromastoid
Fee 41575	Fee: \$2,534.35	<b>Benefit:</b> 75% = \$1900.80	
	retromastoid appr		emoval of, by transmastoid, translabyrinthine or cluding aftercare) not being a service to which item
<b>Fee</b> 41576	Fee: \$3,801.65	<b>Benefit:</b> 75% = \$2851.25	
<b>Fee</b> 41578			emoval of, by transmastoid, translabyrinthine or conjoint surgery, principal surgeon (Anaes.) (Assist.)

T8. SUF		ONS	8. EAR, NOSE AND THROAT	
	Fee: \$2,534.35	<b>Benefit:</b> 75% = \$1900.80		
			, removal of, by transmastoid, translabyrinthine or ) - conjoint surgery, co-surgeon (Assist.)	
Fee 41579	Fee: \$1,900.80	<b>Benefit:</b> 75% = \$1425.60		
	TUMOUR INVO excision of (Anae		L FOSSA, removal of, involving craniotomy and radical	
Fee 41581	Fee: \$2,915.05	<b>Benefit:</b> 75% = \$2186.30		
Fee		ORAL BONE RESECTION ssion of facial nerve (Anaes	for removal of tumour involving mastoidectomy with or ) (Assist.)	
41584	Fee: \$2,000.55	<b>Benefit:</b> 75% = \$1500.45		
	TOTAL TEMPOR	RAL BONE RESECTION for	or removal of tumour (Anaes.) (Assist.)	
Fee 41587	Fee: \$2,724.70	<b>Benefit:</b> 75% = \$2043.55		
	ENDOLYMPHA (Anaes.) (Assist.)	FIC SAC, TRANSMASTOI	D DECOMPRESSION with or without drainage of	
Fee 41590	Fee: \$1,242.65	<b>Benefit:</b> 75% = \$932.00		
	TRANSLABYRI	NTHINE VESTIBULAR NE	ERVE SECTION (Anaes.) (Assist.)	
Fee 41593	Fee: \$1,619.55	<b>Benefit:</b> 75% = \$1214.70		
	RETROLABYRII BOTH (Anaes.) (A		ERVE SECTION or COCHLEAR NERVE SECTION, or	
Fee 41596	Fee: \$1,810.00	<b>Benefit:</b> 75% = \$1357.50		
_	INTERNAL AUD decompression (A	-	ion by middle cranial fossa approach with cranial nerve	
Fee 41599	Fee: \$1,810.00	<b>Benefit:</b> 75% = \$1357.50		
		ATION PROCEDURE - implearing system device, in pat	plantation of titanium fixture for use with implantable ients:	
	- With a permanent or long term hearing loss; and			
	- Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and			
	- With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted.			
	Not being a servic	e associated with a service t	o which items 41554, 45794 or 45797 (Anaes.)	
Fee 41603	Fee: \$524.30	<b>Benefit:</b> 75% = \$393.25	85% = \$445.70	
			ation of transcutaneous abutment implantation of titanium on hearing system device, in patients:	
	- With a perman	ent or long term hearing los	s; and	
Fee 41604	- Unable to utili	se conventional air or bone o	conduction hearing aid for medical or audiological reasons;	
.1004				

T8. SUR	GICAL OPERATI	ONS	8. EAR, NOSE AND THROAT
	and		
		nduction thresholds that accord ng device being inserted.	to recognised criteria for the implantable bone
	Not being a servi	ce associated with a service to v	which items 41554, 45794 or 45797 (Anaes.)
	Fee: \$194.10	<b>Benefit:</b> 75% = \$145.60 85	% = \$165.00
	STAPEDECTOM	IY (Anaes.) (Assist.)	
Fee 41608	Fee: \$1,134.05	<b>Benefit:</b> 75% = \$850.55	
	STAPES MOBIL	ISATION (Anaes.) (Assist.)	
<b>Fee</b> 41611	Fee: \$729.70	<b>Benefit:</b> 75% = \$547.30	
	ROUND WINDO	W SURGERY including repai	r of cochleotomy (Anaes.) (Assist.)
Fee 41614	Fee: \$1,134.05	<b>Benefit:</b> 75% = \$850.55 85	% = \$1049.35
	OVAL WINDOW	V SURGERY, including repair	of fistula, not being a service associated with a service
Fee	to which any othe	r item in this Group applies (A	naes.) (Assist.)
41615	Fee: \$1,134.05	<b>Benefit:</b> 75% = \$850.55 85	% = \$1049.35
_	COCHLEAR IM	PLANT, insertion of, including	mastoidectomy (Anaes.) (Assist.)
Fee 41617	Fee: \$1,972.00	<b>Benefit:</b> 75% = \$1479.00	
			on of, via mastoidectomy, for patients with:
	(a) stable sensorin	neural hearing loss; and	
	(b) outer ear path	ology that prevents the use of a	conventional hearing aid; and
	(c) a PTA4 of less than 80 dBHL; and		
	(d) bilateral, symmetrical hearing loss with PTA thresholds in both ears within 20 dBHL (0.5-4kHz) of each other; and		
	(e) speech perception discrimination of at least 65% correct for word lists with appropriately amplified sound; and		
	(f) a normal middle ear; and		
	(g) normal tympa	nometry; and	
	(h) on audiometry	y, an air-bone gap of less than 1	0 dBHL (0.5-4kHz) across all frequencies; and
	(i) no other inner	ear disorders	
	(Anaes.) (Assist	.)	
<b>Fee</b> 41618	Fee: \$1,953.00	<b>Benefit:</b> 75% = \$1464.75	
	GLOMUS TUM	OUR, transtympanic removal of	f (Anaes.) (Assist.)
<b>Fee</b> 41620	Fee: \$857.95	<b>Benefit:</b> 75% = \$643.50	

T8. SUF	GICAL OPERATIONS	8. EAR, NOSE AND THROAT
	GLOMUS TUMOUR, transmastoid remov	al of, including mastoidectomy (Anaes.) (Assist.)
Fee 41623	<b>Fee:</b> \$1,242.65 <b>Benefit:</b> 75% = \$932.0	0
41025		DDLE EAR, operation for (excluding aftercare) (Anaes.)
<b>Fee</b> 41626	(See para TN.8.4 of explanatory notes to this Ca <b>Fee:</b> \$149.85 <b>Benefit:</b> 75% = \$112.4	
11020	MIDDLE EAR, EXPLORATION OF (Ana	
<b>Fee</b> 41629	<b>Fee:</b> \$542.40 <b>Benefit:</b> 75% = \$406.8	
		NAGE OF (including myringotomy) (Anaes.)
<b>Fee</b> 41632	<b>Fee:</b> \$248.45 <b>Benefit:</b> 75% = \$186.3	
		RANULOMA, CHOLESTEATOMA and POLYP, 1 or more,
Fee 41635	<b>Fee:</b> \$1,190.65 <b>Benefit:</b> 75% = \$893.0	0 85% = \$1105.95
		RANULOMA, CHOLESTEATOMA and POLYP, 1 or more, ar chain reconstruction (Anaes.) (Assist.)
<b>Fee</b> 41638	<b>Fee:</b> \$1,486.20 <b>Benefit:</b> 75% = \$1114.	
	PERFORATION OF TYMPANUM, cauter	risation or diathermy of (Anaes.)
<b>Fee</b> 41641	<b>Fee:</b> \$49.35 <b>Benefit:</b> 75% = \$37.05	85% = \$41.95
	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.)	
Fee		
41644	<b>Fee:</b> \$148.65 <b>Benefit:</b> 75% = \$111.5	
	EAR TOILET requiring use of operating m or without general anaesthesia (Anaes.)	icroscope and microinspection of tympanic membrane with
<b>Fee</b> 41647	<b>Fee:</b> \$114.30 <b>Benefit:</b> 75% = \$85.75	85% = \$97.20
	TYMPANIC MEMBRANE, microinspecti service associated with a service to which a	on of 1 or both ears under general anaesthesia, not being a nother item in this Group applies (Anaes.)
Fee 41650	<b>Fee:</b> \$114.30 <b>Benefit:</b> 75% = \$85.75	85% = \$97.20
	EXAMINATION OF NASAL CAVITY or POSTNASAL SPACE, or NASAL CAVITY AND POSTNASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.)	
Fee 41653	<b>Fee:</b> \$74.85 <b>Benefit:</b> 75% = \$56.15	85% = \$63.65
	NASAL HAEMORRHAGE, POSTERIOR cauterisation and with or without anterior p	, ARREST OF, with posterior nasal packing with or without ack (excluding aftercare) (Anaes.)
<b>Fee</b> 41656	(See para TN.8.4 of explanatory notes to this Ca Fee: \$127.80 Benefit: 75% = \$95.85	
	NOSE, removal of FOREIGN BODY IN, o	other than by simple probing (Anaes.)
<b>Fee</b> 41659	<b>Fee:</b> \$80.70 <b>Benefit:</b> 75% = \$60.55	
<b>Fee</b> 41662	NASAL POLYP OR POLYPI (SIMPLE),	

T8. SUF		NS	8. EAR, NOSE AND THROAT
	(See para TN.8.75 of e <b>Fee:</b> \$85.80	explanatory notes to this C Benefit: 75% = \$64.35	
	NASAL POLYP OF	R POLYPI, removal of (	(Anaes.)
<b>Fee</b> 41668	(See para TN.8.75 of e <b>Fee:</b> \$228.85	explanatory notes to this C Benefit: 75% = \$171.65	
	NASAL SEPTUM, (Anaes.)	SEPTOPLASTY, SUB	MUCOUS RESECTION or closure of septal perforation
<b>Fee</b> 41671	(See para TN.8.104 of <b>Fee:</b> \$502.85	explanatory notes to this Benefit: 75% = \$377.15	
Б	NASAL SEPTUM,	reconstruction of (Anae	es.) (Assist.)
<b>Fee</b> 41672	Fee: \$627.30	<b>Benefit:</b> 75% = \$470.50	0
	general anaesthesia	or diathermy of septum	ns) or cauterisation by chemical means when performed under a or turbinates—one or more of these procedures (including er than a service associated with another operation on the
<b>Fee</b> 41674	Fee: \$104.60	<b>Benefit:</b> 75% = \$78.45	85% = \$88.95
5	NASAL HAEMORI packing or both (An		ng an episode of epistaxis by cauterisation or nasal cavity
<b>Fee</b> 41677	Fee: \$93.65	<b>Benefit:</b> 75% = \$70.25	85% = \$79.65
			h or without stenting not being a service associated with any ned during the postoperative period of a nasal operation
Fee 41683	Fee: \$122.00	<b>Benefit:</b> 75% = \$91.50	85% = \$103.70
			RBINATES, 1 or both sides, not being a service associated Group applies (Anaes.)
<b>Fee</b> 41686	Fee: \$74.85	<b>Benefit:</b> 75% = \$56.15	85% = \$63.65
	TURBINECTOMY	or turbinectomies, parti	ial or total, unilateral (Anaes.)
Fee 41689	<b>Fee:</b> \$142.05	<b>Benefit:</b> 75% = \$106.55	5
	TURBINATES, sub	mucous resection of, ur	nilateral (Anaes.)
Fee 41692	<b>Fee:</b> \$185.25	<b>Benefit:</b> 75% = \$138.95	5
			TURE AND LAVAGE OF (Anaes.)
<b>Fee</b> 41698	<b>Fee:</b> \$33.85	<b>Benefit:</b> 75% = \$25.40	85% = \$28.80
11070	MAXILLARY ANT	RUM, proof puncture a	and lavage of, under general anaesthesia (requiring admission with a service to which another item in this Group applies
<b>Fee</b> 41701	<b>Fee:</b> \$95.60	<b>Benefit:</b> 75% = \$71.70	
	MAXILLARY ANT	TRUM, LAVAGE OF	each attendance at which the procedure is performed,
Fee		Banafite 75% \$28.25	
41704	Fee: \$37.80	<b>Benefit:</b> 75% = \$28.35	ðð% = \$32.13

T8. SUF	GICAL OPERATI	ONS 8. EAR, NOSE AND THROAT			
	MAXILLARY A	RTERY, transantral ligation of (Anaes.) (Assist.)			
<b>Fee</b> 41707	Fee: \$466.75	<b>Benefit:</b> 75% = \$350.10			
	ANTROSTOMY (RADICAL) (Anaes.) (Assist.)				
<b>Fee</b> 41710	<b>Fee:</b> \$542.40	<b>Benefit:</b> 75% = \$406.80			
		(RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy			
	(Anaes.) (Assist.)	• •			
Fee 41713	Fee: \$631.10	<b>Benefit:</b> 75% = \$473.35			
	ANTRUM, intrar	nasal operation on, or removal of foreign body from (Anaes.) (Assist.)			
<b>Fee</b> 41716	<b>Fee:</b> \$307.70	<b>Benefit:</b> 75% = \$230.80			
11/10		age of, through tooth socket (Anaes.)			
Fee					
41719	<b>Fee:</b> \$122.35	<b>Benefit:</b> 75% = \$91.80 85% = \$104.00 ISTULA, plastic closure of (Anaes.) (Assist.)			
Fee	OKOANTKAL F	ISTOLA, plastic closure of (Allaes.) (Assist.)			
41722	<b>Fee:</b> \$611.40	<b>Benefit:</b> 75% = \$458.55 85% = \$526.70			
Fee	ETHMOIDAL A	RTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.)			
41725	Fee: \$466.75	<b>Benefit:</b> 75% = \$350.10			
_	LATERAL RHIN	JOTOMY with removal of tumour (Anaes.) (Assist.)			
Fee 41728	Fee: \$933.65	<b>Benefit:</b> 75% = \$700.25			
	DERMOID OF N	IOSE, excision of, with intranasal extension (Anaes.) (Assist.)			
Fee 41729	<b>Fee:</b> \$591.70	<b>Benefit:</b> 75% = \$443.80			
	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.)				
_	(Assist.)				
<b>Fee</b> 41731	Fee: \$808.60	<b>Benefit:</b> 75% = \$606.45			
	RADICAL FROM	NTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.)			
<b>Fee</b> 41734	<b>Fee:</b> \$1,055,10	<b>Benefit:</b> 75% = \$791.35			
41734		JS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on			
	(Anaes.) (Assist.)	-			
<b>Fee</b> 41737	Fee: \$502.85	<b>Benefit:</b> 75% = \$377.15			
		JS, catheterisation of (Anaes.)			
<b>Fee</b> 41740	Fee: \$61.20	<b>Benefit:</b> 75% = \$45.90			
41740		JS, trephine of (Anaes.) (Assist.)			
Fee					
41743	<b>Fee:</b> \$351.15	<b>Benefit:</b> 75% = \$263.40			
Fee	FRONTAL SINU	JS, radical obliteration of (Anaes.) (Assist.)			
41746	Fee: \$808.60	<b>Benefit:</b> 75% = \$606.45 85% = \$723.90			
<b>Fee</b> 41749	ETHMOIDAL SI	NUSES, external operation on (Anaes.) (Assist.)			

T8. SUF	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT			
	Fee: \$631.10	<b>Benefit:</b> 75% = \$473.35			
	SPHENOIDAL S	SINUS, intranasal operation on (Anaes.) (Assist.)			
Fee 41752	Fee: \$307.70	<b>Benefit:</b> 75% = \$230.80			
	EUSTACHIAN TUBE, catheterisation of (Anaes.)				
<b>Fee</b> 41755	<b>Fee:</b> \$48.40	<b>Benefit:</b> 75% = \$36.30 85% = \$41.15			
		PY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and			
Б	LARYNX, one o	r more of these procedures, unilateral or bilateral examination (Anaes.)			
<b>Fee</b> 41764	Fee: \$127.80	<b>Benefit:</b> 75% = \$95.85 85% = \$108.65			
	NASOPHARYN	GEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.)			
<b>Fee</b> 41767	Fee: \$766.90	<b>Benefit:</b> 75% = \$575.20 85% = \$682.20			
41707		POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.)			
Fee					
41770	Fee: \$729.70	<b>Benefit:</b> 75% = \$547.30			
_	PHARYNGEAL	POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.)			
<b>Fee</b> 41773	Fee: \$611.40	<b>Benefit:</b> 75% = \$458.55			
	CRICOPHARYN	NGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.)			
<b>Fee</b> 41776	Fee: \$609.65	<b>Benefit:</b> 75% = \$457.25			
41770		MY (lateral), with or without total excision of tongue (Anaes.) (Assist.)			
Fee	FHARINGOIO	IN I (lateral), with of without total excision of tongue (Anaes.) (Assist.)			
41779	Fee: \$729.70	<b>Benefit:</b> 75% = \$547.30			
	PARTIAL PHAI	RYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.)			
Fee 41782	Fee: \$990.70	<b>Benefit:</b> 75% = \$743.05 85% = \$906.00			
	PARTIAL PHAI	RYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.)			
	(Assist.)				
<b>Fee</b> 41785	<b>Fee:</b> \$1,229.00	<b>Benefit:</b> 75% = \$921.75			
41705		OPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.)			
	(Assist.)	or max moor east 1, while or while at tonsheetonity, by any means (Anaes.)			
Fee	East #7// 00	Demo#41 750/ 0575.00			
41786	<b>Fee:</b> \$766.90	<b>Benefit:</b> 75% = \$575.20			
		AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, onsillectomy, 1 or more stages, including any revision procedures within 12 months			
	(Anaes.) (Assist.				
Fee	<b>D (((((((((((((</b>				
41787	<b>Fee:</b> \$591.70	<b>Benefit:</b> 75% = \$443.80 85% = \$507.00			
	examination of the	and adenoids, removal of, in a patient aged less than 12 years (including any ne postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies			
Amend	(Anaes.)				
<b>Fee</b> 41789	Fee: \$307.70	<b>Benefit:</b> 75% = \$230.80			
41789	Fee: \$307.70	<b>Benefit:</b> 75% = \$230.80			

T8. SUR	GICAL OPERAT	IONS 8. EAR, NOSE AND THROAT	
Amend	examination of t	s and adenoids, removal of, in a patient 12 years of age or over (including any he postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies (Anaes.)	
<b>Fee</b> 41793	Fee: \$386.55	<b>Benefit:</b> 75% = \$289.95	
Fee		ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general owing removal of (Anaes.)	
<b>ree</b> 41797	Fee: \$149.85	<b>Benefit:</b> 75% = \$112.40	
F		val of (including any examination of the postnasal space and nasopharynx and the cal anaesthetic), not being a service to which item 41764 applies (Anaes.)	
<b>Fee</b> 41801	Fee: \$169.55	<b>Benefit:</b> 75% = \$127.20	
	LINGUAL TON	SIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.)	
<b>Fee</b> 41804	Fee: \$93.65	<b>Benefit:</b> 75% = \$70.25	
	PERITONSILLA	AR ABSCESS (quinsy), incision of (Anaes.)	
<b>Fee</b> 41807	Fee: \$72.90	<b>Benefit:</b> 75% = \$54.70 85% = \$62.00	
	UVULOTOMY	or UVULECTOMY (Anaes.)	
<b>Fee</b> 41810	Fee: \$37.05	<b>Benefit:</b> 75% = \$27.80 85% = \$31.50	
	VALLECULAR	OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.)	
<b>Fee</b> 41813	Fee: \$370.80	<b>Benefit:</b> 75% = \$278.10	
		COPY (with rigid oesophagoscope) (Anaes.)	
<b>Fee</b> 41816	Fee: \$193.10	<b>Benefit:</b> $75\% = \$144.85$ $85\% = \$164.15$	
41010		COPY (with rigid oesophagoscope), with biopsy (Anaes.)	
<b>Fee</b> 41822	<b>Fee:</b> \$248.45	Benefit: 75% = \$186.35	
Б	OESOPHAGOS	COPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.)	
<b>Fee</b> 41825	Fee: \$370.80	<b>Benefit:</b> 75% = \$278.10	
	OESOPHAGEA	L STRICTURE, dilatation of, without oesophagoscopy (Anaes.)	
Fee 41828	Fee: \$54.35	<b>Benefit:</b> 75% = \$40.80 85% = \$46.20	
	Oesophagus, end	doscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.)	
Fee 41831	Fee: \$371.45	<b>Benefit:</b> 75% = \$278.60 85% = \$315.75	
	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.)		
<b>Fee</b> 41832	Fee: \$237.75	<b>Benefit:</b> 75% = \$178.35 85% = \$202.10	
		DMY (TOTAL) (Anaes.) (Assist.)	
<b>Fee</b> 41834	<b>Fee:</b> \$1,341.40	<b>Benefit:</b> 75% = \$1006.05	
	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.)		
Fee			

T8. SUF	GICAL OPERAT	ONS	8. EAR, NOSE AND THROAT	
	SUPRAGLOTTIC LARYNGECTOMY inclu		neostomy (Anaes.) (Assist.)	
Fee 41840	Fee: \$1,581.35	<b>Benefit:</b> 75% = \$1186.05		
		RYNGECTOMY or PRIMARY REST yngectomy USING STOMACH OR E	FORATION OF ALIMENTARY CONTINUITY BOWEL (Anaes.) (Assist.)	
<b>Fee</b> 41843	Fee: \$1,390.60	<b>Benefit:</b> 75% = \$1042.95		
Fee		GOSCOPY (Anaes.) (Assist.)		
41855	Fee: \$299.85	<b>Benefit:</b> 75% = \$224.90 GOSCOPY with removal of juvenile p	anillomata (Anaes) (Assist)	
<b>Fee</b> 41858		of explanatory notes to this Category) <b>Benefit:</b> 75% = \$385.65		
Fee	MICROLARYN (Assist.)	GOSCOPY with removal of benign les	sions of the larynx by laser surgery (Anaes.)	
41861	Fee: \$628.75	<b>Benefit:</b> 75% = \$471.60		
	MICROLARYN	GOSCOPY WITH REMOVAL OF TU	JMOUR (Anaes.) (Assist.)	
<b>Fee</b> 41864	Fee: \$424.00	<b>Benefit:</b> 75% = \$318.00		
	MICROLARYN	GOSCOPY with arytenoidectomy (An	aes.) (Assist.)	
<b>Fee</b> 41867	Fee: \$638.25	<b>Benefit:</b> 75% = \$478.70		
	LARYNGEAL V	VEB, division of, using microlarygosco	opic techniques (Anaes.)	
<b>Fee</b> 41868	Fee: \$404.40	<b>Benefit:</b> 75% = \$303.30		
	INJECTION OF	VOCAL CORD BY TEFLON, FAT, O	COLLAGEN OR GELFOAM (Anaes.) (Assist.)	
<b>Fee</b> 41870	Fee: \$473.30	<b>Benefit:</b> 75% = \$355.00		
	LARYNX, FRA	CTURED, operation for (Anaes.) (Ass	ist.)	
Fee 41873	Fee: \$611.40	<b>Benefit:</b> 75% = \$458.55 85% = \$5	26.70	
			URE with or without cordectomy (Anaes.)	
<b>Fee</b> 41876	Fee: \$611.40	<b>Benefit:</b> 75% = \$458.55 85% = \$5	26.70	
		STY or TRACHEOPLASTY, includin		
<b>Fee</b> 41879	Fee: \$990.70	<b>Benefit:</b> 75% = \$743.05		
F	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.)			
Fee 41880	Fee: \$264.40	<b>Benefit:</b> 75% = \$198.30		
		MY by open exposure of the trachea, in yroid isthmus, where performed (Anae	ncluding separation of the strap muscles or es.) (Assist.)	
<b>Fee</b> 41881	Fee: \$418.05	<b>Benefit:</b> 75% = \$313.55		
			hnique, using mini tracheostomy device (Anaes.)	
<b>Fee</b> 41884	Fee: \$94.75	<b>Benefit:</b> 75% = \$71.10		

T8. SUR	GICAL OPERATION	S	8. EAR, NOSE AND THROAT
		AGEAL FISTULA, formation ling associated endoscopic proc	of, as a secondary procedure following cedures (Anaes.) (Assist.)
Fee 41885	<b>Fee:</b> \$299.55	<b>Benefit:</b> 75% = \$224.70 85% =	= \$254.65
		l of foreign body in (Anaes.)	
<b>Fee</b> 41886	Fee: \$185.25	<b>Benefit:</b> 75% = \$138.95 85% =	= \$157.50
Fee	BRONCHOSCOPY	with dilatation of tracheal stric	ture (Anaes.)
<b>гее</b> 41904	Fee: \$256.50	<b>Benefit:</b> 75% = \$192.40 85% =	= \$218.05
	NASAL SEPTUM B	UTTON, insertion of (Anaes.)	
Fee 41907	<b>Fee:</b> \$127.80	<b>Benefit:</b> 75% = \$95.85 85% =	\$108.65
		SALIVARY GLAND, transpos	
<b>Fee</b> 41910		<b>Benefit:</b> 75% = \$304.55	
	GICAL OPERATION		9. OPHTHALMOLOGY
	Group T8. Surgical	Operations	
		-	. Ophthalmology
			general anaesthesia, not being a service associated
Fee 42503	Fee: \$106.65	<b>Benefit:</b> 75% = \$80.00	
			stent system into the trabecular meshwork, if:
	(a) conservative ther	apies have failed, are likely to f	ail, or are contraindicated; and
		formed by a specialist with train of Training in Micro-Bypass Gl	ning that is recognised by the Conjoint Committee aucoma Surgery
	(Anaes.)		
<b>Fee</b> 42504 S	Fee: \$312.95	xplanatory notes to this Category) <b>Benefit:</b> 75% = \$234.75 85% = <b>Safety Net Cap:</b> \$46.95	= \$266.05
	Complete removal fr	om the eye of a trans-trabecula	r drainage device or devices, with or without plications necessitating complete removal. (Anaes.)
	Fee: \$312.95	<b>Benefit:</b> 75% = \$234.75 85% =	A

GICAL OPERATIO	NS	9. OPHTHALMOLOGY		
EYE, ENUCLEAT	ION OF, with or without sphere implant (Anae	es.) (Assist.)		
Fee: \$500.75	<b>Benefit:</b> 75% = \$375.60 85% = \$425.65			
EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.)				
Fee: \$633.75	<b>Benefit:</b> 75% = \$475.35			
EYE, enucleation o (Assist.)	f, with insertion of hydroxy apatite implant or	similar coralline implant (Anaes.)		
Fee: \$730.50	<b>Benefit:</b> 75% = \$547.90			
	RATION OF (Anaes.) (Assist.)			
Fee: \$500.75	<b>Benefit:</b> 75% – \$375.60 85% – \$425.65			
		CLERAL BALL OR CARTILAGE		
Fee: \$633.75	<b>Benefit:</b> 75% – \$475 35			
ANOPHTHALMIC procedure, or REM	CORBIT, INSERTION OF CARTILAGE OR . OVAL OF IMPLANT FROM SOCKET, or PI	LACEMENT OF A MOTILITY		
Fee: \$367.70	<b>Benefit:</b> 75% = \$275.80			
ANOPHTHALMIC	C SOCKET, treatment of, by insertion of a wire	ed-in conformer, integrated implant or		
Fee: \$1,251.95	<b>Benefit:</b> 75% = \$939.00			
ORBIT, SKIN GRA	AFT TO, as a delayed procedure (Anaes.)			
Fee: \$212.85	<b>Benefit:</b> 75% = \$159.65 85% = \$180.95			
		MUCOUS MEMBRANE GRAFTING		
Fee: \$422.50	<b>Benefit:</b> 75% = \$316.90			
ORBIT, EXPLORA	ATION with or without biopsy, requiring REM	OVAL OF BONE (Anaes.) (Assist.)		
Fee: \$657.35	<b>Benefit:</b> 75% = \$493.05			
ORBIT, EXPLORA	ATION OF, with drainage or biopsy not requiri	ng removal of bone (Anaes.) (Assist.)		
Fee: \$422.50	<b>Benefit:</b> 75% = \$316.90			
		th or without temporalis muscle		
Fee: \$868.40	<b>Benefit:</b> 75% = \$651.30			
ORBIT, EXPLORA (Anaes.) (Assist.)	ATION OF, with removal of tumour or foreign	body, requiring removal of bone		
Fee: \$1,236.35	<b>Benefit:</b> 75% = \$927.30			
		foreign body (Anaes.) (Assist.)		
	EYE, ENUCLEAT         Fee: \$500.75         EYE, ENUCLEAT         Fee: \$633.75         EYE, enucleation of (Assist.)         Fee: \$730.50         GLOBE, EVISCER         Fee: \$500.75         GLOBE, EVISCER         Fee: \$633.75         ANOPHTHALMIC         procedure, or REM         INTEGRATING PI         Fee: \$367.70         ANOPHTHALMIC         dermofat graft, as a         Fee: \$1,251.95         ORBIT, SKIN GRA         Fee: \$212.85         CONTRACTED SC         AND STENT MOU         Fee: \$422.50         ORBIT, EXPLORA         Fee: \$422.50         ORBIT, EXPLORA         Fee: \$868.40         ORBIT, EXPLORA         Fee: \$868.40         ORBIT, EXPLORA         Fee: \$1,236.35	EYE, ENUCLEATION OF, with insertion of integrated implant (JFee: \$633.75Benefit: 75% = \$475.35EYE, enucleation of, with insertion of hydroxy apatite implant or (Assist.)Fee: \$730.50Benefit: 75% = \$547.90GLOBE, EVISCERATION OF (Anaes.) (Assist.)Fee: \$500.75Benefit: 75% = \$375.6085% = \$425.65GLOBE, EVISCERATION OF, AND INSERTION OF INTRASC (Anaes.) (Assist.)Fee: \$633.75Benefit: 75% = \$475.35ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR procedure, or REMOVAL OF IMPLANT FROM SOCKET, or PIINTEGRATING PEG by drilling into an existing orbital implant (Fee: \$367.70Benefit: 75% = \$275.80ANOPHTHALMIC SOCKET, treatment of, by insertion of a wire dermofat graft, as a secondary procedure (Anaes.) (Assist.)Fee: \$1,251.95Benefit: 75% = \$939.00ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.)Fee: \$212.85Benefit: 75% = \$159.6585% = \$180.95CONTRACTED SOCKET, RECONSTRUCTION INCLUDING AND STENT MOULD (Anaes.) (Assist.)Fee: \$422.50Benefit: 75% = \$316.90ORBIT, EXPLORATION OF, with drainage or biopsy not requiring Fee: \$422.50Benefit: 75% = \$316.90ORBIT, EXPLORATION OF, with or without skin graft and wit transplant (Anaes.) (Assist.)Fee: \$868.40 <td col<="" td=""></td>		

T8. SUR	GICAL OPERATIO	ONS 9. OPHTHALMOLOGY		
	ORBIT, exploration	on of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.)		
Fee 42543	Fee: \$919.65	<b>Benefit:</b> 75% = \$689.75		
		ession of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the bital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.)		
Fee 42545	<b>Fee:</b> \$1,330.15	<b>Benefit:</b> 75% = \$997.65		
42343	. ,	<b>Benefit</b> 75% = \$997.03 <b>MENINGES</b> , incision of (Anaes.) (Assist.)		
<b>Fee</b> 42548	<b>Fee:</b> \$790.15	Benefit: 75% = \$592.65		
	EYE, PENETRAT	FING WOUND OR RUPTURE OF, not involving intraocular structures repair f cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.)		
Fee 42551	Fee: \$657.35	<b>Benefit:</b> 75% = \$493.05 85% = \$572.65		
	EYE, PENETRAT repair (Anaes.) (A	FING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue ssist.)		
Fee 42554	Fee: \$766.90	<b>Benefit:</b> 75% = \$575.20		
	EYE, PENETRAT (Anaes.) (Assist.)	TING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair		
<b>Fee</b> 42557	<b>Fee:</b> \$1,071.95	<b>Benefit:</b> 75% = \$804.00		
-	INTRAOCULAR	INTRAOCULAR FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.)		
Fee 42563	Fee: \$540.00	<b>Benefit:</b> 75% = \$405.00 85% = \$459.00		
-	INTRAOCULAR	FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.)		
Fee 42569	Fee: \$1,071.95	<b>Benefit:</b> 75% = \$804.00		
	ORBITAL ABSC	ESS OR CYST, drainage of (Anaes.)		
Fee 42572	Fee: \$122.15	<b>Benefit:</b> 75% = \$91.65 85% = \$103.85		
Amend	DERMOID, perio	rbital, excision of, on a patient 10 years of age or over (Anaes.)		
Fee 42573	Fee: \$236.65	<b>Benefit:</b> 75% = \$177.50 85% = \$201.20		
	DERMOID, orbit	al, excision of (Anaes.) (Assist.)		
Fee 42574	Fee: \$502.85	<b>Benefit:</b> 75% = \$377.15 85% = \$427.45		
		extirpation of (Anaes.)		
Fee 42575	Fee: \$86.05	<b>Benefit:</b> 75% = \$64.55 85% = \$73.15		
Amend		rbital, excision of, on a patient under 10 years of age (Anaes.)		
Fee 42576	Fee: \$307.70	<b>Benefit:</b> 75% = \$230.80 85% = \$261.55		
	ECTROPION OR	ENTROPION, tarsal cauterisation of (Anaes.)		
Fee 42581	<b>Fee:</b> \$122.15	<b>Benefit:</b> 75% = \$91.65 85% = \$103.85		
<b>Fee</b> 42584		Y (Anaes.) (Assist.)		

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY
	Fee: \$288.00	<b>Benefit:</b> 75% = \$216.00 85% = \$244	.80
	TRICHIASIS (d each eyelid (Ana		nent of by cryotherapy, laser or electrolysis -
Fee 42587	Fee: \$54.10	<b>Benefit:</b> 75% = \$40.60 85% = \$46.00	0
Fee	TRICHIASIS (d	ue to trachoma), treatment of by cryother	rapy, laser or electrolysis - each eyelid (Anaes.)
42588	Fee: \$54.10	<b>Benefit:</b> 75% = \$40.60 85% = \$46.00	0
	CANTHOPLAS	TY, medial or lateral (Anaes.) (Assist.)	
<b>Fee</b> 42590	Fee: \$352.05 Extended Medi	<b>Benefit:</b> 75% = \$264.05 85% = \$299 care Safety Net Cap: \$281.65	.25
Б	LACRIMAL GI	AND, excision of palpebral lobe (Anaes	.)
Fee 42593	Fee: \$212.85	<b>Benefit:</b> 75% = \$159.65	
<b>D</b>	LACRIMAL SA	C, excision of, or operation on (Anaes.)	(Assist.)
Fee 42596	Fee: \$524.30	<b>Benefit:</b> 75% = \$393.25 85% = \$445	5.70
		NALICULAR SYSTEM, establishment 1 eye (Anaes.) (Assist.)	of patency by closed operation using silicone
Fee		• • • • • •	
42599	Fee: \$657.35	<b>Benefit:</b> 75% = \$493.05 85% = \$572	
Fac	LACRIMAL CA (Assist.)	NALICULAR SYSTEM, establishment	of patency by open operation, 1 eye (Anaes.)
Fee 42602	Fee: \$657.35	<b>Benefit:</b> 75% = \$493.05 85% = \$572	2.65
Ess	LACRIMAL CA	NALICULUS, immediate repair of (Ana	aes.) (Assist.)
Fee 42605	Fee: \$485.00	<b>Benefit:</b> 75% = \$363.75 85% = \$412	2.25
Fee	LACRIMAL DF	AINAGE by insertion of glass tube, as a	n independent procedure (Anaes.) (Assist.)
42608	Fee: \$312.95	<b>Benefit:</b> 75% = \$234.75 85% = \$266	0.05
_		AL TUBE (unilateral), removal or replac uction, unilateral, with or without lavage	
Fee 42610	Fee: \$100.15	<b>Benefit:</b> 75% = \$75.15 85% = \$85.15	5
		AL TUBE (bilateral), removal or replace bilateral, with or without lavage - under g	ement of, or LACRIMAL PASSAGES, probing general anaesthesia (Anaes.)
Fee 42611	Fee: \$150.20	<b>Benefit:</b> 75% = \$112.65 85% = \$127	7.70
	probing to establ		cement of, or LACRIMAL PASSAGES, or site of obstruction, unilateral, including hich item 42610 applies (excluding aftercare)
<b>Fee</b> 42614	(See para TN.8.4 c <b>Fee:</b> \$50.25	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$37.70 85% = \$42.75	5
	to establish pater		ment of, or LACRIMAL PASSAGES, probing obstruction, bilateral, including lavage, not 2611 applies (excluding aftercare)
Fee 42615	Fee: \$75.15	<b>Benefit:</b> 75% = \$56.40 85% = \$63.90	0

T8. SUR	GICAL OPERAT	TONS 9. OPHTHALMOLOGY	
	PUNCTUM SN	IP operation (Anaes.)	
<b>Fee</b> 42617	Fee: \$142.50	<b>Benefit:</b> 75% = \$106.90 85% = \$121.15	
	PUNCTUM, oc	clusion of, by use of a plug (Anaes.)	
<b>Fee</b> 42620	Fee: \$54.80	<b>Benefit:</b> 75% = \$41.10 85% = \$46.60	
	PUNCTUM, pe	rmanent occlusion of, by use of electrical cautery (Anaes.)	
<b>Fee</b> 42622	Fee: \$86.05	<b>Benefit:</b> 75% = \$64.55 85% = \$73.15	
	DACRYOCYS	FORHINOSTOMY (Anaes.) (Assist.)	
Fee 42623	Fee: \$727.80	<b>Benefit:</b> 75% = \$545.85	
E	DACRYOCYS (Anaes.) (Assist	FORHINOSTOMY where a previous dacryocystorhinostomy has been performed .)	
<b>Fee</b> 42626	Fee: \$1,173.75	<b>Benefit:</b> 75% = \$880.35 85% = \$1089.05	
		ORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps	
Fee	(Anaes.) (Assist	.)	
42629	Fee: \$884.15	<b>Benefit:</b> 75% = \$663.15	
	CONJUNCTIV. (Anaes.)	AL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap	
<b>Fee</b> 42632	Fee: \$122.15	<b>Benefit:</b> 75% = \$91.65 85% = \$103.85	
	CORNEAL PER	RFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.)	
Fee 42635	Fee: \$312.95	<b>Benefit:</b> 75% = \$234.75 85% = \$266.05	
-	CONJUNCTIV	AL GRAFT OVER CORNEA (Anaes.) (Assist.)	
<b>Fee</b> 42638	Fee: \$391.25	<b>Benefit:</b> 75% = \$293.45 85% = \$332.60	
	AUTOCONJUN	CTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.)	
<b>Fee</b> 42641	Fee: \$508.55	<b>Benefit:</b> 75% = \$381.45 85% = \$432.30	
		CLERA, complete removal of embedded foreign body from - not more than once on the same practitioner (excluding aftercare) (Anaes.)	
<b>Fee</b> 42644	(See para TN.8.78 <b>Fee:</b> \$75.05	B, TN.8.4 of explanatory notes to this Category) Benefit: $75\% = $56.30$ $85\% = $63.80$	
	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.)		
<b>Fee</b> 42647	Fee: \$212.85	<b>Benefit:</b> 75% = \$159.65 85% = \$180.95	
	CORNEA, epith	elial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.)	
<b>Fee</b> 42650	(See para TN.8.4 <b>Fee:</b> \$75.05	of explanatory notes to this Category) <b>Benefit:</b> $75\% = $56.30$ $85\% = $63.80$	
		elial debridement for eliminating band keratopathy (Anaes.)	
<b>Fee</b> 42651	<b>Fee:</b> \$167.30	<b>Benefit:</b> 75% = \$125.50 85% = \$142.25	
Amend Fee	Corneal collage	n cross linking, on a patient with a corneal ectatic disorder, with evidence of	

	RGICAL OPERATI	ONS 9. OPHTHALMOLOG		
42652	progression—per eye (Anaes.)			
	(See para TN.8.136	of explanatory notes to this Category)		
	Fee: \$1,248.65	<b>Benefit:</b> 75% = \$936.50 85% = \$1163.95		
-	CORNEA transpl	antation of (Anaes.) (Assist.)		
Fee 42653	Fee: \$1,360.75	<b>Benefit:</b> 75% = \$1020.60		
	CORNEA, transp	antation of, second and subsequent procedures (Anaes.) (Assist.)		
Fee 42656	<b>Fee:</b> \$1,737.10	<b>Benefit:</b> 75% = \$1302.85		
42050		antation of, full thickness, including collection of donor material (Anaes.) (Assist.)		
Fee	-	- · · · · · · · · · · · · · · · · · · ·		
42662	Fee: \$938.85	<b>Benefit:</b> 75% = \$704.15		
	SCLERA, transpl (Assist.)	antation of, superficial or lamellar, including collection of donor material (Anaes.)		
Fee	(Assist.)			
42665	Fee: \$626.05	<b>Benefit:</b> 75% = \$469.55 85% = \$541.35		
		NEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to n where a reduction of 2 dioptres of astigmatism is obtained, including any associated		
Fee 42667	Fee: \$147.65	<b>Benefit:</b> 75% = \$110.75 85% = \$125.55		
	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or			
-	operating microsc			
Fee 42668	Fee: \$78.35	<b>Benefit:</b> 75% = \$58.80 85% = \$66.60		
		SONS, to correct corneal astigmatism of more than $1^{1/2}$ dioptres following anterior		
1	procedure (Anaes	ncluding appropriate measurements and calculations, performed as an independent ) (Assist.)		
<b>Fee</b> 42672	procedure (Anaes			
42672	procedure (Anaes (See para TN.8.79 ( Fee: \$938.85 ADDITIONAL C	) (Assist.) f explanatory notes to this Category) <b>Benefit:</b> $75\% = \$704.15$ $85\% = \$854.15$ ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, fate measurements and calculations, performed in conjunction with other anterior		
	procedure (Anaes (See para TN.8.79 c Fee: \$938.85 ADDITIONAL C including appropri	) (Assist.) f explanatory notes to this Category) <b>Benefit:</b> $75\% = \$704.15$ $85\% = \$854.15$ ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, fate measurements and calculations, performed in conjunction with other anterior		
42672 Fee	procedure (Anaes (See para TN.8.79 ( Fee: \$938.85 ADDITIONAL C including approprisegment surgery ( Fee: \$469.35	) (Assist.) f explanatory notes to this Category) <b>Benefit:</b> 75% = $704.15$ 85% = $854.15$ ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, that measurements and calculations, performed in conjunction with other anterior Anaes.) (Assist.)		
42672 Fee 42673 Fee	procedure (Anaes (See para TN.8.79 ( Fee: \$938.85 ADDITIONAL C including approprisegment surgery ( Fee: \$469.35 CONJUNCTIVA	) (Assist.) f explanatory notes to this Category) Benefit: $75\% = \$704.15$ $85\% = \$854.15$ ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, fate measurements and calculations, performed in conjunction with other anterior Anaes.) (Assist.) Benefit: $75\% = \$352.05$ $85\% = \$398.95$ biopsy of, as an independent procedure		
42672 Fee 42673	procedure (Anaes (See para TN.8.79 of Fee: \$938.85 ADDITIONAL C including approprisegment surgery ( Fee: \$469.35 CONJUNCTIVA Fee: \$120.35	) (Assist.) f explanatory notes to this Category) Benefit: $75\% = \$704.15$ $85\% = \$854.15$ ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, ate measurements and calculations, performed in conjunction with other anterior Anaes.) (Assist.) Benefit: $75\% = \$352.05$ $85\% = \$398.95$ biopsy of, as an independent procedure Benefit: $75\% = \$90.30$ $85\% = \$102.30$		
42672 Fee 42673 Fee	procedure (Anaes (See para TN.8.79 of Fee: \$938.85 ADDITIONAL C including approprisegment surgery ( Fee: \$469.35 CONJUNCTIVA Fee: \$120.35 CONJUNCTIVA	) (Assist.) f explanatory notes to this Category) Benefit: $75\% = \$704.15$ $85\% = \$854.15$ ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, fate measurements and calculations, performed in conjunction with other anterior Anaes.) (Assist.) Benefit: $75\% = \$352.05$ $85\% = \$398.95$ biopsy of, as an independent procedure		
42672 Fee 42673 Fee 42676 Fee	procedure (Anaes (See para TN.8.79 of Fee: \$938.85 ADDITIONAL C including approprisegment surgery ( Fee: \$469.35 CONJUNCTIVA Fee: \$120.35 CONJUNCTIVA which treatment i	) (Assist.) f explanatory notes to this Category) <b>Benefit:</b> 75% = \$704.15 85% = \$854.15 ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, fate measurements and calculations, performed in conjunction with other anterior Anaes.) (Assist.) <b>Benefit:</b> 75% = \$352.05 85% = \$398.95 biopsy of, as an independent procedure <b>Benefit:</b> 75% = \$90.30 85% = \$102.30 CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at a given including any associated consultation (Anaes.)		
42672 Fee 42673 Fee 42676	procedure (Anaes (See para TN.8.79 ( Fee: \$938.85 ADDITIONAL C including approprisegment surgery ( Fee: \$469.35 CONJUNCTIVA Fee: \$120.35 CONJUNCTIVA which treatment i Fee: \$63.45	) (Assist.) f explanatory notes to this Category) Benefit: $75\% = \$704.15 \ 85\% = \$854.15$ ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, fate measurements and calculations, performed in conjunction with other anterior Anaes.) (Assist.) Benefit: $75\% = \$352.05 \ 85\% = \$398.95$ biopsy of, as an independent procedure Benefit: $75\% = \$90.30 \ 85\% = \$102.30$ CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at a given including any associated consultation (Anaes.) Benefit: $75\% = \$47.60 \ 85\% = \$53.95$		
42672 Fee 42673 Fee 42676 Fee 42677 Fee	procedure (Anaes (See para TN.8.79 ( Fee: \$938.85 ADDITIONAL C including approprisegment surgery ( Fee: \$469.35 CONJUNCTIVA Fee: \$120.35 CONJUNCTIVA which treatment i Fee: \$63.45 CONJUNCTIVA	) (Assist.) f explanatory notes to this Category) Benefit: 75% = \$704.15 85% = \$854.15 ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, fate measurements and calculations, performed in conjunction with other anterior Anaes.) (Assist.) Benefit: 75% = \$352.05 85% = \$398.95 biopsy of, as an independent procedure Benefit: 75% = \$90.30 85% = \$102.30 CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at a given including any associated consultation (Anaes.) Benefit: 75% = \$47.60 85% = \$53.95 cryotherapy to, for melanotic lesions or similar using CO <sup>2</sup> or N <sup>2</sup> 0 (Anaes.)		
42672 Fee 42673 Fee 42676 Fee 42677	<ul> <li>procedure (Anaes</li> <li>(See para TN.8.79 of</li> <li>Fee: \$938.85</li> <li>ADDITIONAL C</li> <li>including approprisegment surgery (</li> <li>Fee: \$469.35</li> <li>CONJUNCTIVA</li> <li>Fee: \$120.35</li> <li>CONJUNCTIVA which treatment i</li> <li>Fee: \$63.45</li> <li>CONJUNCTIVA</li> <li>Fee: \$312.95</li> </ul>	) (Assist.) f explanatory notes to this Category) Benefit: 75% = \$704.15 85% = \$854.15 ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, fate measurements and calculations, performed in conjunction with other anterior Anaes.) (Assist.) Benefit: 75% = \$352.05 85% = \$398.95 biopsy of, as an independent procedure Benefit: 75% = \$90.30 85% = \$102.30 CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at a given including any associated consultation (Anaes.) Benefit: 75% = \$47.60 85% = \$53.95 cryotherapy to, for melanotic lesions or similar using CO <sup>2</sup> or N <sup>2</sup> 0 (Anaes.) Benefit: 75% = \$234.75 85% = \$266.05		
42672 Fee 42673 Fee 42676 Fee 42677 Fee	<ul> <li>procedure (Anaes</li> <li>(See para TN.8.79 of</li> <li>Fee: \$938.85</li> <li>ADDITIONAL C</li> <li>including approprisegment surgery (</li> <li>Fee: \$469.35</li> <li>CONJUNCTIVA</li> <li>Fee: \$120.35</li> <li>CONJUNCTIVA which treatment i</li> <li>Fee: \$63.45</li> <li>CONJUNCTIVA</li> <li>Fee: \$312.95</li> </ul>	) (Assist.) f explanatory notes to this Category) Benefit: 75% = \$704.15 85% = \$854.15 ORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, fate measurements and calculations, performed in conjunction with other anterior Anaes.) (Assist.) Benefit: 75% = \$352.05 85% = \$398.95 biopsy of, as an independent procedure Benefit: 75% = \$90.30 85% = \$102.30 CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at a given including any associated consultation (Anaes.) Benefit: 75% = \$47.60 85% = \$53.95 cryotherapy to, for melanotic lesions or similar using CO <sup>2</sup> or N <sup>2</sup> 0 (Anaes.)		

T8. SUF	GICAL OPERAT	IONS	9. OPHTHALMOLOGY
	PTERYGIUM, 1	removal of (Anaes.)	
Fee 42686	Fee: \$284.75	<b>Benefit:</b> 75% = \$213.60 85% = \$242.05	5
12000		, removal of, not being a service associated	
Fee 42689	Fee: \$122.15	<b>Benefit:</b> 75% = \$91.65 85% = \$103.85	
42089		DUR, removal of, excluding Pterygium (Ana	Das) (Assist)
Fee			
42692	<b>Fee:</b> \$288.00	<b>Benefit:</b> 75% = \$216.00 85% = \$244.80	
	(Assist.)	OUR, excision of, requiring keratectomy or s	sclerectomy, excluding Pterygium (Anaes.)
Fee	` ´		_
42695	<b>Fee:</b> \$469.35	<b>Benefit:</b> 75% = \$352.05 85% = \$398.95	
		CTION, excluding surgery performed for the reater than 3 dioptres following the remova	
Fee		of explanatory notes to this Category)	
42698	<b>Fee:</b> \$618.80	<b>Benefit:</b> 75% = \$464.10 85% = \$534.10	
		R LENS, insertion of, excluding surgery pe anisometropia greater than 3 dioptres follo	rformed for the correction of refractive owing the removal of cataract in the first eye
<b>Fee</b> 42701	(See para TN.8.80 <b>Fee:</b> \$345.15	) of explanatory notes to this Category) <b>Benefit:</b> 75% = \$258.90 85% = \$293.40	)
	for the correctio	CTION AND INSERTION OF INTRAOCU n of refractive error except for anisometrop: ract in the first eye (Anaes.)	
<b>Fee</b> 42702	Fee: \$791.45 Extended Medi	<b>Benefit:</b> 75% = \$593.60 85% = \$706.75 care Safety Net Cap: \$118.75	5
		R LENS or IRIS PROSTHESIS insertion of (Anaes.) (Assist.)	f, into the posterior chamber with fixation to
Fee 42703	Fee: \$595.20	<b>Benefit:</b> 75% = \$446.40 85% = \$510.50	)
		R LENS, REMOVAL or REPOSITIONING a service to which item 42701 applies (Ana	• • • •
Fee 42704	Fee: \$485.00	<b>Benefit:</b> 75% = \$363.75 85% = \$412.25	5
	LENS EXTRACTION AND INSERTION OF INTRAOCULAR LENS, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye, performed in association with insertion of a trans-trabecular drainage device or devices, in a patient diagnosed with open angle glaucoma who is not adequately responsive to topical anti-glaucoma medications or who is intolerant of anti-glaucoma medication. (Anaes.)		
<b>Fee</b> 42705	Fee: \$948.05 Extended Medi	<b>Benefit:</b> 75% = \$711.05 85% = \$863.35 care Safety Net Cap: \$142.25	5
	performed for th	R LENS, REMOVAL of and REPLACEM the correction of refractive error except for an e correction of cataract in the first eye (Anaes.)	ENT with a different lens, excluding surgery nisometropia greater than 3 dioptres
Fee			

T8. SUR	GICAL OPERATIC	ONS		9. OPHTHALMOLOGY
		LENS, removal of, and re ris or sclera (Anaes.) (As	eplacement with a lens inserted sist.)	into the posterior chamber
Fee 42710	Fee: \$938.85	<b>Benefit:</b> 75% = \$704.15	5 85% = \$854.15	
	IRIS SUTURING, (Anaes.) (Assist.)	McCannell technique or	similar, for fixation of intraocu	lar lens or repair of iris defect
Fee 42713	<b>Fee:</b> \$391.25	<b>Benefit:</b> 75% = \$293.45	5 85% - \$332.60	
42713			uding subsequent needlings (A	naes) (Assist)
<b>Fee</b> 42716	<b>Fee:</b> \$1,244.15	<b>Benefit:</b> 75% = \$933.15		naes.) (13515t.)
_			ULAR or LENS MATERIAL, which item 42698, 42702, 427	
Fee 42719	Fee: \$540.00	<b>Benefit:</b> 75% = \$405.00	85% = \$459.00	
	Vitrectomy via par	s plana sclerotomy, inclu	ding one or more of the follow	ing:
	(a) removal of vitre	eous;	-	
	(b) division of vitreous bands;			
	(c) removal of epiretinal membranes;			
Fee	(d) capsulotomy (A	Anaes.) (Assist.)		
42725	Fee: \$1,392.65	<b>Benefit:</b> 75% = \$1044.5	50	
		S PLANA LENSECTON 42702, 42719, or 42725 (	MY combined with vitrectomy, (Anaes.) (Assist.)	not being a service associated
Fee 42731	Fee: \$1,580.55	<b>Benefit:</b> 75% = \$1185.4	45	
	Capsulotomy, othe or 42731 applies (A		than a service associated with	a service to which item 42725
Fee 42734	Fee: \$312.95	<b>Benefit:</b> 75% = \$234.75	5 85% = \$266.05	
	PARACENTESIS therapeutic substar	OF ANTERIOR CHAM	BER OR VITREOUS CAVITY ueous or vitreous humours for	
<b>Fee</b> 42738	Fee: \$312.95	of explanatory notes to this ( Benefit: 75% = \$234.75 re Safety Net Cap: \$250	585% = \$266.05	
_	therapeutic substan purposes, one or m	nces, or the removal of aq	BER OR VITREOUS CAVITY ueous or vitreous humours for t procedure, for a patient requir	diagnostic or therapeutic
Amend Fee	Fee: \$312.95	of explanatory notes to this $G$ <b>Benefit:</b> 75% = \$234.75	585% = \$266.05	
42739	Extended Medica	re Safety Net Cap: \$250	.40	
<b>Fee</b> 42740			APEUTIC SUBSTANCES, or t of, as a procedure associated w	

T8. SUF		IONS		9. OPHTHALMOLOGY
	(Anaes.)			
	Fee: \$312.95	of explanatory notes to this Benefit: 75% = \$234.7 Care Safety Net Cap: \$250	5 85% = \$266.05	
			nerapeutic substance, for the lar degeneration, 1 or more	e treatment of subfoveal choroidal of (Anaes.)
<b>Fee</b> 42741	(See para TN.8.81 <b>Fee:</b> \$312.95	of explanatory notes to this C Benefit: 75% = \$234.7		
Fee	ANTERIOR CH. (Assist.)	AMBER, IRRIGATION C	OF BLOOD FROM, as an in	ndependent procedure (Anaes.)
42743	Fee: \$657.35	<b>Benefit:</b> 75% = \$493.0	5 85% = \$572.65	
<b>Fee</b> 42744	Needle revision of <b>Fee:</b> \$312.75	of glaucoma filtration bleb <b>Benefit:</b> 75% = \$234.6	, following glaucoma filteri	ng procedure (Anaes.)
		ltering operation for, when		ve failed, are likely to fail, or are
<b>Fee</b> 42746	Fee: \$993.70	<b>Benefit:</b> 75% = \$745.3	0	
	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes (Assist.)			
<b>Fee</b> 42749	Fee: \$1,244.15	<b>Benefit:</b> 75% = \$933.1	5	
	GLAUCOMA, in device (Anaes.) (	-	e incorporating an extraocul	ar reservoir for, such as a Molteno
<b>Fee</b> 42752	(See para TN.8.83 <b>Fee:</b> \$1,392.65	of explanatory notes to this <b>C</b> <b>Benefit:</b> 75% = \$1044.		
Fac	GLAUCOMA, re device (Anaes.)	emoval of drainage device	incorporating an extraocula	ar reservoir for, such as a Molteno
<b>Fee</b> 42755	Fee: \$172.15	<b>Benefit:</b> 75% = \$129.1	5 85% = \$146.35	
1		ne treatment of primary co laucoma drainage devices	ngenital glaucoma, excludir (Anaes.) (Assist.)	ng the minimally invasive
<b>Fee</b> 42758	Fee: \$727.80	<b>Benefit:</b> 75% = \$545.8	5	
5	DIVISION OF A by laser (Anaes.)		OR SYNECHIAE, as an in-	dependent procedure, other than
<b>Fee</b> 42761	Fee: \$540.00	<b>Benefit:</b> 75% = \$405.0	0 85% = \$459.00	
		including excision of tume er (Anaes.) (Assist.)	our of iris) OR IRIDOTOM	Y, as an independent procedure,
<b>Fee</b> 42764	Fee: \$540.00	<b>Benefit:</b> 75% = \$405.0	0 85% = \$459.00	
				ND IRIS, excision of (Anaes.)
<b>Fee</b> 42767	Fee: \$1,134.50	<b>Benefit:</b> 75% = \$850.9	0	
Fee	· · · ·	UCTIVE procedures for th	e treatment of intractable g	laucoma, treatment to 1 eye, to a

T8. SUF	RGICAL OPERATIONS	9. OPHTHALMOLOGY	
42770	maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)		
	(See para TN.8.82 of explanatory notes to this Category) <b>Fee:</b> \$306.75 <b>Benefit:</b> 75% = \$230.10 85% = \$260.75		
	DETACHED RETINA, pneumatic retinopexy for, not being a service a	associated with a service to which	
Fee	item 42776 applies (Anaes.) (Assist.)		
42773	Fee: \$938.85         Benefit: 75% = \$704.15         85% = \$854.15		
_	DETACHED RETINA, buckling or resection operation for (Anaes.) (A	Assist.)	
Fee 42776	<b>Fee:</b> \$1,392.65 <b>Benefit:</b> 75% = \$1044.50		
	DETACHED RETINA, revision of scleral buckling operation for (Ana	es.) (Assist.)	
Fee 42779	<b>Fee:</b> \$1,737.10 <b>Benefit:</b> 75% = \$1302.85		
	LASER TRABECULOPLASTY, for the treatment of glaucoma. Each of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.)	treatment to 1 eye, to a maximum	
<b>Fee</b> 42782	(See para TN.8.84 of explanatory notes to this Category) <b>Fee:</b> \$469.35 <b>Benefit:</b> 75% = \$352.05 85% = \$398.95		
	LASER IRIDOTOMY - each treatment episode to 1 eye, to a maximum year period (Anaes.) (Assist.)	n of 3 treatments to that eye in a 2	
<b>Fee</b> 42785	(See para TN.8.85 of explanatory notes to this Category) <b>Fee:</b> \$367.70 <b>Benefit:</b> 75% = \$275.80 85% = \$312.55		
	Laser capsulotomy—each treatment episode to one eye, to a maximum year period—other than a service associated with a service to which ite (Assist.)		
<b>Fee</b> 42788	(See para TN.8.86 of explanatory notes to this Category) <b>Fee:</b> \$367.70 <b>Benefit:</b> 75% = \$275.80 85% = \$312.55		
	Laser vitreolysis or corticolysis of lens material or fibrinolysis, excludi vitreous cavity—each treatment to one eye, to a maximum of 3 treatme (Anaes.) (Assist.)	• • •	
<b>Fee</b> 42791	(See para TN.8.87 of explanatory notes to this Category) <b>Fee:</b> \$367.70 <b>Benefit:</b> 75% = \$275.80 85% = \$312.55		
	DIVISION OF SUTURE BY LASER following glaucoma filtration sur a maximum of 2 treatments to that eye in a 2 year period (Anaes.)	rgery, each treatment to 1 eye, to	
<b>Fee</b> 42794	(See para TN.8.88 of explanatory notes to this Category)           Fee: \$70.45         Benefit: 75% = \$52.85         85% = \$59.90		
<b>D</b>	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.)		
Fee 42801	<b>Fee:</b> \$1,092.25 <b>Benefit:</b> 75% = \$819.20		
	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 1 choroidal melanomas, removal of (Anaes.) (Assist.)	125), for the treatment of	
<b>Fee</b> 42802	Fee: \$545.95         Benefit: 75% = \$409.50		
<b>Fee</b> 42805	TANTALUM MARKERS, surgical insertion to the sclera to localise the planning of radiotherapy of choroidal melanomas, 1 or more (Anaes.) (		

GICAL OPERAT	IONS 9. OPHTHALMOLOGY		
Fee: \$610.30	<b>Benefit:</b> 75% = \$457.75 85% = \$525.60		
IRIS TUMOUR,	laser photocoagulation of (Anaes.) (Assist.)		
Fee: \$367.70	<b>Benefit:</b> 75% = \$275.80 85% = \$312.55		
PHOTOMYDRI	ASIS, laser		
Fee: \$370.20	<b>Benefit:</b> 75% = \$277.65 85% = \$314.70		
Laser peripheral	iridoplasty		
Fee: \$370.20	<b>Benefit:</b> 75% = \$277.65 85% = \$314.70		
	coagulation of, not being a service associated with photodynamic therapy with es.) (Assist.)		
Fee: \$469.35	<b>Benefit:</b> 75% = \$352.05 85% = \$398.95		
	PEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery or (Anaes.)		
Fee: \$590.70	<b>Benefit:</b> 75% = \$443.05 85% = \$506.00		
	ARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular		
malformations (A	Anaes.)		
Fee: \$469.35	<b>Benefit:</b> 75% = \$352.05 85% = \$398.95		
Removal of scler (Anaes.)	ral buckling material, from an eye having undergone previous scleral buckling surgery		
Fee: \$172.15	<b>Benefit:</b> 75% = \$129.15 85% = \$146.35		
	VITY, removal of silicone oil or other liquid vitreous substitutes from, during a than that in which the vitreous substitute is inserted (Anaes.) (Assist.)		
Fee: \$657 35	<b>Benefit:</b> 75% = \$493.05		
RETINA, CRYC	OTHERAPY TO, as an independent procedure, or when performed in conjunction with		
<b>Fee:</b> \$610.30	<b>Benefit:</b> 75% = \$457.75 85% = \$525.60		
OCULAR TRAN	NSILLUMINATION, for the diagnosis and measurement of intraocular tumours		
``´´	<b>Benefit:</b> 75% = \$70.55 85% = \$79.95		
	R INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure		
	<b>Benefit:</b> 75% = \$54.55 85% = \$61.80		
SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.)			
Fee: \$610.30	<b>Benefit:</b> 75% = \$457.75		
MUSCLES, on a	ATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 patient aged 14 years or under, or where the patient has had previous squint, retinal or rations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.)		
Fee: \$758.95	<b>Benefit:</b> 75% = \$569.25		
	IRIS TUMOUR,Fee: \$367.70PHOTOMYDRI.Fee: \$370.20Laser peripheralFee: \$370.20RETINA, photocverteporfin (AnalFee: \$469.35PHOTOTHERALfor refractive errorFee: \$469.35PHOTOTHERALfor refractive errorFee: \$469.35PHOTOTHERALfor refractive errorFee: \$469.35Removal of scler(Anaes.)Fee: \$172.15VITREOUS CANprocedure other toFee: \$657.35RETINA, CRYCitem 42809 or 42Fee: \$610.30OCULAR TRAN(Anaes.)Fee: \$94.05RETROBULBALFee: \$72.70SQUINT, OPERMUSCLES on aextra ocular oper		

T8. SUF		TIONS		9. OPHTHALMOLOGY
_		RATION FOR, ON 1 OR BO a patient aged 15 years or ov	OTH EYES, the operation involver (Anaes.) (Assist.)	ring a total of 3 OR MORE
Fee 42839	Fee: \$727.80	<b>Benefit:</b> 75% = \$545.85		
	MUSCLES, on	a patient aged 14 years or ur	OTH EYES, the operation involved of the patient has had a patient with concurrent the patient with concurrent with concurrent the patient with concurrent with concurrent the patient with concurrent with concurrent with concurrent with concurrent with concurrent with concurrent with with concurrent with concurrent with with concurrent with with concurrent with with concurrent with with with with with with with wit	d previous squint, retinal or
Fee 42842	Fee: \$907.65	<b>Benefit:</b> 75% = \$680.75		
		ENT OF ADJUSTABLE SU eration for correction of squ	ΓURES, 1 or both eyes, as an ind int (Anaes.)	dependent procedure
<b>Fee</b> 42845	(See para TN.8.8) <b>Fee:</b> \$197.10	9 of explanatory notes to this Ca Benefit: 75% = \$147.85		
_	SQUINT, musc over (Anaes.) (A	1	eim type, or similar operation) o	n a patient aged 15 years or
Fee 42848	Fee: \$727.80	<b>Benefit:</b> 75% = \$545.85		
	under, or where		eim type, or similar operation) o squint, retinal or extra ocular op lisease (Anaes.) (Assist.)	
Fee 42851	Fee: \$907.65	<b>Benefit:</b> 75% = \$680.75		
	RUPTURED M (Anaes.) (Assist		AMENT or ruptured EXTRAOC	ULAR MUSCLE, repair of
Fee 42854	Fee: \$422.50	<b>Benefit:</b> 75% = \$316.90	85% = \$359.15	
E		OF WOUND FOLLOWING apsed iris (Anaes.) (Assist.)	G INTRAOCULAR PROCEDU	RES with or without
Fee 42857	Fee: \$422.50	<b>Benefit:</b> 75% = \$316.90	85% = \$359.15	
_	EYELID (upper retractors (Anae		x or other non-autogenous graft	to, with recession of the lid
Fee 42860	Fee: \$938.85	<b>Benefit:</b> 75% = \$704.15	85% = \$854.15	
-	EYELID, recess	sion of (Anaes.) (Assist.)		
Fee 42863	Fee: \$805.95	<b>Benefit:</b> 75% = \$604.50	85% = \$721.25	
_	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.)			0 1
Fee 42866	Fee: \$782.35	<b>Benefit:</b> 75% = \$586.80	85% = \$697.65	
Fee	EYELID closur	e in facial nerve paralysis, ir	sertion of foreign implant for (A	anaes.) (Assist.)
42869	Fee: \$571.25	<b>Benefit:</b> 75% = \$428.45	85% = \$486.55	
Fac			to correct for a reduced field of y ptosis to a position below the sup	
Fee 42872	Fee: \$250.45	<b>Benefit:</b> 75% = \$187.85	85% = \$212.90	
Fee	Photodynamic t	herapy, one eye, including th	ne infusion of Verteporfin contin	uously through a peripheral

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY
43021	vein, using a nor neovascularisatio	6	f 689nm, for the treatment of choroidal
	Fee: \$473.50	<b>Benefit:</b> 75% = \$355.15 85	% = \$402.50
Faa		using a non-thermal laser at a wa	Infusion of Verteporfin continuously through a avelength of 689nm, for the treatment of choroidal
Fee 43022	Fee: \$568.25	<b>Benefit:</b> 75% = \$426.20 85	% = \$483.55
Ess			namic therapy, where a session of therapy which would has been discontinued on medical grounds.
Fee 43023	Fee: \$92.05	<b>Benefit:</b> 75% = \$69.05 85%	5 = \$78.25
T8. SUF	RGICAL OPERAT	IONS	10. OPERATIONS FOR OSTEOMYELITIS
	Group T8. Surg	ical Operations	
		Subgroup 10. Op	perations For Osteomyelitis
		C	HRONIC
	OPERATION O	N SKULL (Anaes.) (Assist.)	
<b>Fee</b> 43521	Fee: \$483.35	<b>Benefit:</b> 75% = \$362.55	
	Operation on sternum, clavicle, rib, metacarpus, carpus, phalanx, metatarsus, tarsus, mandible or max (other than alveolar margins), by open or arthroscopic means, for septic arthritis or osteomyelitis—on approach, inclusive of the adjoining joint (H) (Anaes.) (Assist.)		
<b>New</b> 43527	Fee: \$370.80	<b>Benefit:</b> 75% = \$278.10	
	-	-	numerus or femur, by open or arthroscopic means, for nclusive of the adjoining joint (Anaes.) (Assist.)
<b>New</b> 43530	Fee: \$370.80	<b>Benefit:</b> 75% = \$278.10 85	% = \$315.20
		ne or pelvic bones, by open or a clusive of the adjoining joint (A	rthroscopic means, for septic arthritis or osteomyelitis— naes.) (Assist.)
<b>New</b> 43533	Fee: \$611.40	<b>Benefit:</b> 75% = \$458.55 85	% = \$526.70
T8. SUF	RGICAL OPERAT	IONS	11. PAEDIATRIC
	Group T8. Surg	ical Operations	
	Subgroup 11. Paediatric		
		SURGERY IN NEC	NATE OR YOUNG CHILD
	INTESTINAL M resection (Anaes		t volvulus, laparotomy for, not involving bowel
<b>Fee</b> 43801	Fee: \$996.10	<b>Benefit:</b> 75% = \$747.10	
<b>Fee</b> 43804		IALROTATION with or withou h or without formation of stoma	t volvulus, laparotomy for, with bowel resection and (Anaes.) (Assist.)

T8. SUR	GICAL OPERATIO	ONS 11. PAEDIATRIC	
	Fee: \$1,060.55	<b>Benefit:</b> 75% = \$795.45	
Amend Fee	UMBILICAL, EP (Anaes.)	IGASTRIC OR LINEA ALBA HERNIA, repair of, on a patient under 10 years of age	
43805	Fee: \$370.80	<b>Benefit:</b> 75% = \$278.10	
	DUODENAL AT (Assist.)	RESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.)	
<b>Fee</b> 43807	Fee: \$1,157.05	<b>Benefit:</b> 75% = \$867.80	
Fee	JEJUNAL ATRE	SIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.)	
43810	Fee: \$1,349.90	<b>Benefit:</b> 75% = \$1012.45	
		EUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal r without meconium peritonitis (Anaes.) (Assist.)	
<b>Fee</b> 43813	Fee: \$1,349.90	<b>Benefit:</b> 75% = \$1012.45	
-		A, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with item 43813 applies, laparotomy for (Anaes.) (Assist.)	
<b>Fee</b> 43816	Fee: \$1,253.40	<b>Benefit:</b> 75% = \$940.05	
	0 0	laparotomy for, with or without frozen section biopsies and formation of stoma	
Fee	(Anaes.) (Assist.)		
43819	Fee: \$1,012.40	<b>Benefit:</b> 75% = \$759.30	
_	ANORECTAL M	ALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.)	
<b>Fee</b> 43822	Fee: \$1,012.40	<b>Benefit:</b> 75% = \$759.30	
		IMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other oup applies (Anaes.) (Assist.)	
<b>Fee</b> 43825	Fee: \$1,157.05	<b>Benefit:</b> 75% = \$867.80	
		TAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including or stoma formation (Anaes.) (Assist.)	
Fee 43828	Fee: \$1,278.30	<b>Benefit:</b> 75% = \$958.75	
	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible laparotomy for (Anaes.) (Assist.)		
<b>Fee</b> 43831	Fee: \$996.10	<b>Benefit:</b> 75% = \$747.10	
Amend Fee	Branchial fistula,	removal of, on a patient under 10 years of age (Anaes.) (Assist.)	
43832	Fee: \$679.40	<b>Benefit:</b> 75% = \$509.55	
	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses of stoma formation (Anaes.) (Assist.)		
<b>Fee</b> 43834	Fee: \$1,157.05	<b>Benefit:</b> 75% = \$867.80	
Amend		D, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel tient under 10 years of age (Anaes.) (Assist.)	
<b>Fee</b> 43835	Fee: \$705.15	<b>Benefit:</b> 75% = \$528.90	

T8. SUR	GICAL OPERATI	ONS	11. PAEDIATRIC
1		DIAPHRAGMATIC HERNIA, repair by the ned in the first 24 hours of life (Anaes.) (As	
<b>Fee</b> 43837	Fee: \$1,446.25	<b>Benefit:</b> 75% = \$1084.70	
Amend		ernia, congential repair of, by thoracic or ab as 31569 to 31581 apply, on a patient under	
<b>Fee</b> 43838	Fee: \$1,294.90	<b>Benefit:</b> 75% = \$971.20	
		DIAPHRAGMATIC HERNIA, repair by th of life and before 20 days of age (Anaes.) (	
<b>Fee</b> 43840	Fee: \$1,253.40	<b>Benefit:</b> 75% = \$940.05	
Amend Fee		NGUINAL HERNIA OR INFANTILE HY 3 or 43835 applies, on a patient under 10 ye	DROCELE, repair of, not being a service to ars of age (Anaes.) (Assist.)
43841	Fee: \$628.30	<b>Benefit:</b> 75% = \$471.25	
Fee		ATRESIA (with or without repair of trach being a service to which item 43846 applie	
43843	Fee: \$1,928.45	<b>Benefit:</b> 75% = \$1446.35	
		ATRESIA (with or without repair of trach	
<b>Fee</b> 43846	Fee: \$2,073.05	<b>Benefit:</b> 75% = \$1554.80	
	OESOPHAGEAI	ATRESIA, gastrostomy for (Anaes.) (Ass	ist.)
<b>Fee</b> 43849	Fee: \$530.30	<b>Benefit:</b> 75% = \$397.75	
Fee	OESOPHAGEAL anastomosis (Ana	ATRESIA, thoracotomy for, and division les.) (Assist.)	of tracheo-oesophageal fistula without
43852	Fee: \$1,687.25	<b>Benefit:</b> 75% = \$1265.45	
Fee		ATRESIA, delayed primary anastomosis	for (Anaes.) (Assist.)
43855	<b>Fee:</b> \$1,783.85	<b>Benefit:</b> 75% = \$1337.90	
<b>Fee</b> 43858	OESOPHAGEAL Fee: \$626.70	ATRESIA, cervical oesophagostomy for ( Benefit: 75% = \$470.05	Anaes.) (Assist.)
+3030	CONGENITAL O	CYSTADENOMATOID MALFORMATIC horacotomy and lung resection for (Anaes.)	
<b>Fee</b> 43861	Fee: \$1,735.65	<b>Benefit:</b> 75% = \$1301.75	
	GASTROSCHISIS, operation for (Anaes.) (Assist.)		
<b>Fee</b> 43864	Fee: \$1,301.70	<b>Benefit:</b> 75% = \$976.30	
	GASTROSCHIS	S or Exomphalos, secondary operation for,	with removal of silo (Anaes.) (Assist.)
<b>Fee</b> 43867	Fee: \$723.15	<b>Benefit:</b> 75% = \$542.40	
-	EXOMPHALOS	containing small bowel only, operation for	(Anaes.) (Assist.)
<b>Fee</b> 43870	Fee: \$1,012.40	<b>Benefit:</b> 75% = \$759.30	

T8. SUF	RGICAL OPERATI	ONS	11. PAEDIATRIC	
	EXOMPHALOS	containing small bowel and other viscera	a, operation for (Anaes.) (Assist.)	
<b>Fee</b> 43873	Fee: \$1,349.90	<b>Benefit:</b> 75% = \$1012.45		
-	SACROCOCCY	GEAL TERATOMA, excision of, by pos	terior approach (Anaes.) (Assist.)	
<b>Fee</b> 43876	Fee: \$1,157.05	<b>Benefit:</b> 75% = \$867.80		
	SACROCOCCY (Anaes.) (Assist.)		nbined posterior and abdominal approach	
Fee				
43879	<b>Fee:</b> \$1,349.90	<b>Benefit:</b> 75% = \$1012.45		
Fee	CLOACAL EXS	TROPHY, operation for (Anaes.) (Assist	.)	
43882	Fee: \$1,735.65	<b>Benefit:</b> 75% = \$1301.75 85% = \$165	50.95	
		THORACIC SUR	GERY	
	TRACHEO-OES	OPHAGEAL FISTULA without atresia,	division and repair of (Anaes.) (Assist.)	
Fee 43900	Fee: \$1,157.05	<b>Benefit:</b> 75% = \$867.80		
	OESOPHAGEAI	ATRESIA or CORROSIVE OESOPHA utilizing gastric tube, jejunum or colon (A		
Fee 43903	Fee: \$1,928.45	<b>Benefit:</b> 75% = \$1446.35		
-		resection of congenital, anastomic or con item 43903 applies (Anaes.) (Assist.)	rosive stricture and anastomosis, not being a	
<b>Fee</b> 43906	Fee: \$1,687.25	<b>Benefit:</b> 75% = \$1265.45		
	TRACHEOMAL	ACIA, aortopexy for (Anaes.) (Assist.)		
Fee 43909	Fee: \$1,687.25	<b>Benefit:</b> 75% = \$1265.45		
	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or m teratoma (Anaes.) (Assist.)			
Fee 43912	Fee: \$1,594.05	<b>Benefit:</b> 75% = \$1195.55		
	EVENTRATION	, plication of diaphragm for (Anaes.) (As	ssist.)	
<b>Fee</b> 43915	Fee: \$1,205.25	<b>Benefit:</b> 75% = \$903.95		
		ABDOMINAL SUF	RGERY	
	HYPERTROPHI	C PYLORIC STENOSIS, pyloromyotom	ny for (Anaes.) (Assist.)	
<b>Fee</b> 43930	Fee: \$463.50	<b>Benefit:</b> 75% = \$347.65		
	IDIOPATHIC IN	TUSSUSCEPTION, laparotomy and max	nipulative reduction of (Anaes.) (Assist.)	
<b>Fee</b> 43933	Fee: \$542.55	<b>Benefit:</b> 75% = \$406.95		
-		FION, laparotomy and resection with ana	stomosis (Anaes.) (Assist.)	
<b>Fee</b> 43936	Fee: \$1,012.40	<b>Benefit:</b> 75% = \$759.30		
43730			phalos or gastroschisis, ropeir of (Apage)	
Eas	(Assist.)	intA tonowing neonatal closure of exom	phalos or gastroschisis, repair of (Anaes.)	
Fee	Fee: \$771.35	<b>Benefit:</b> 75% = \$578.55		

T8. SUF	GICAL OPERATI	ONS 11. PAEDIATRI
	ABDOMINAL W	ALL VITELLO INTESTINAL REMNANT, excision of (Anaes.)
Fee 43942	Fee: \$241.10	<b>Benefit:</b> 75% = \$180.85
	PATENT VITEL	LO INTESTINAL DUCT, excision of (Anaes.) (Assist.)
<b>Fee</b> 43945	Fee: \$1,012.40	<b>Benefit:</b> 75% = \$759.30
	UMBILICAL GR	ANULOMA, excision of, under general anaesthesia (Anaes.)
Fee 43948	Fee: \$144.75	<b>Benefit:</b> 75% = \$108.60
		PHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for
Fee	without gastrostor	my (Anaes.) (Assist.)
43951	Fee: \$906.65	<b>Benefit:</b> 75% = \$680.00
		PHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for (Anaes.) (Assist.)
Fee 43954	Fee: \$1,108.95	<b>Benefit:</b> 75% = \$831.75
	GASTRO-OESO	PHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or rnia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.)
<b>Fee</b> 43957	Fee: \$1,205.25	<b>Benefit:</b> 75% = \$903.95
	ANORECTAL M	ALFORMATION, perineal anoplasty of (Anaes.) (Assist.)
<b>Fee</b> 43960	Fee: \$424.00	<b>Benefit:</b> 75% = \$318.00
	ANORECTAL M	ALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.)
Fee 43963	Fee: \$1,687.25	<b>Benefit:</b> 75% = \$1265.45
	ANORECTAL M (Assist.)	ALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.)
<b>Fee</b> 43966	Fee: \$1,928.45	<b>Benefit:</b> 75% = \$1446.35
		LOACA, total correction of, with genital repair using posterior sagittal approach, with tomy (Anaes.) (Assist.)
<b>Fee</b> 43969	Fee: \$2,651.60	<b>Benefit:</b> 75% = \$1988.70
	CHOLEDOCHA	L CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.)
<b>Fee</b> 43972	Fee: \$1,928.45	<b>Benefit:</b> 75% = \$1446.35
		L CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.)
<b>Fee</b> 43975	Fee: \$2,265.95	<b>Benefit:</b> 75% = \$1699.50
		SIA, portoenterostomy for (Anaes.) (Assist.)
<b>Fee</b> 43978	Fee: \$1,928.45	<b>Benefit:</b> 75% = \$1446.35
15710	NEPHROBLAST	OMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy luding associated biopsies, where no other intra-abdominal procedure is performed
<b>Fee</b> 43981	Fee: \$530.30	<b>Benefit:</b> 75% = \$397.75

T8. SUR	GICAL OPERATIO	ONS 11. PAEDIATRIC	
	NEPHROBLAST	OMA, radical nephrectomy for (Anaes.) (Assist.)	
<b>Fee</b> 43984	<b>Fee:</b> \$1,349.90	<b>Benefit:</b> 75% = \$1012.45	
		OMA, radical excision of (Anaes.) (Assist.)	
<b>Fee</b> 43987	<b>Fee:</b> \$1,494.65	<b>Benefit:</b> 75% = \$1121.00	
	Aganglionosis Co	li, definitive resection with pull-through anastomosis, with or without frozen section anglionic segment extends to sigmoid colon (Anaes.) (Assist.)	
Fee 43990	<b>Fee:</b> \$1,832.10	<b>Benefit:</b> 75% = \$1374.10	
		li, definitive resection with pull-through anastomosis, with or without frozen section anglionic segment extends into descending or transverse colon with or without resiting	
Fee 43993	Fee: \$1,976.65	<b>Benefit:</b> 75% = \$1482.50	
Fee		li, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or de ileocolic anastomosis (Anaes.) (Assist.)	
43996	Fee: \$2,217.75	<b>Benefit:</b> 75% = \$1663.35	
-	Aganglionosis Co	li, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.)	
Fee 43999	Fee: \$277.30	<b>Benefit:</b> 75% = \$208.00	
Amend Fee		nation of, on a patient under 2 years of age, under general anaesthesia with full or removal of polyp or similar lesion (Anaes.) (Assist.)	
44101	Fee: \$347.60	<b>Benefit:</b> 75% = \$260.70	
Amend Fee		nation of, on a patient 2 years of age or over, under general anaesthesia with full or removal of polyp or similar lesion (Anaes.) (Assist.)	
44102	Fee: \$267.35	<b>Benefit:</b> 75% = \$200.55	
Amend Fee	RECTAL PROLA under general ana	APSE, SUBMUCOSAL or perirectal injection for, on a patient under 2 years of age, esthesia (Anaes.)	
44104	Fee: \$61.05	<b>Benefit:</b> 75% = \$45.80 85% = \$51.90	
Amend Fee	RECTAL PROLA under general ana	APSE, SUBMUCOSAL or perirectal injection for, on a patient 2 years of age or over, esthesia (Anaes.)	
44105	Fee: \$46.90	<b>Benefit:</b> 75% = \$35.20 85% = \$39.90	
Fee	INGUINAL HER	NIA repair at age less than 12 months (Anaes.) (Assist.)	
<b>Fee</b> 44108	Fee: \$511.35	<b>Benefit:</b> 75% = \$383.55	
<b>D</b>	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair, at age, less than 12 months including orchidopexy when performed (Anaes.) (Assist.)		
Fee 44111	Fee: \$598.95	<b>Benefit:</b> 75% = \$449.25 85% = \$514.25	
_	INGUINAL HER (Assist.)	NIA repair at age less than 12 months when orchidopexy also required (Anaes.)	
Fee 44114	Fee: \$598.95	<b>Benefit:</b> 75% = \$449.25	
		MISCELLANEOUS SURGERY	

T8. SUR	GICAL OPERAT	IONS	11. PAEDIATRIC	
-	LYMPHADENE (Assist.)	ECTOMY, for atypical myc	cobacterial infection or other granulomatous disease (Anaes.)	
<b>Fee</b> 44130	Fee: \$482.05	<b>Benefit:</b> 75% = \$361.53	55 85% = \$409.75	
-	TORTICOLLIS,	open division of sternoma	astoid muscle for (Anaes.) (Assist.)	
<b>Fee</b> 44133	Fee: \$382.65	<b>Benefit:</b> 75% = \$287.0	00	
<b>F</b>	INGROWN TO	E NAIL, operation for, und	ler general anaesthesia (Anaes.)	
<b>Fee</b> 44136	Fee: \$176.35	<b>Benefit:</b> 75% = \$132.3	30 85% = \$149.90	
T8. SUR	GICAL OPERAT	IONS	12. AMPUTATIONS	
	Group T8. Surg	ical Operations		
		Su	ubgroup 12. Amputations	
Amend	Amputation of h	and, transcarpal (H) (Anae	es.) (Assist.)	
Fee 44325	Fee: \$307.70	<b>Benefit:</b> 75% = \$230.8	30	
Amend Fee	Amputation of h	and, proximal to wrist radio	iocarpal joint, through forearm (H) (Anaes.) (Assist.)	
44328	Fee: \$370.80	<b>Benefit:</b> 75% = \$278.10	0	
Fee	AMPUTATION	AT SHOULDER (Anaes.)	) (Assist.)	
44331	Fee: \$611.40	<b>Benefit:</b> 75% = \$458.53	55	
Fee	INTERSCAPUL	OTHORACIC AMPUTAT	TION (Anaes.) (Assist.)	
44334	Fee: \$1,242.65	<b>Benefit:</b> 75% = \$932.00	00 85% = \$1157.95	
	Amputation of one digit of one foot, distal to metatarsal head, including any of the following (if performed):			
	(a) resection of bone or joint;			
	(b) excision of neuroma;			
	(c) skin cover wi	th homodigital flaps		
Amend Fee	(H) (Anaes.) (As	ssist.)		
44338	Fee: \$149.85	<b>Benefit:</b> 75% = \$112.4	40	
	Amputation of 2 performed):	digits of one foot, distal to	o metatarsal head, including any of the following (if	
	(a) resection of b	oone or joint;		
	(b) excision of n	euroma;		
	(c) skin cover wi	th homodigital flaps		
Amend Fee	(H) (Anaes.) (As	ssist.)		
44342	Fee: \$228.85	<b>Benefit:</b> 75% = \$171.6		
Amend	Amputation of 3	digits of one foot, distal to	o metatarsal head, including any of the following (if	

T8. SUR	GICAL OPERATIONS 12. AMPUTATIONS		
<b>Fee</b> 44346	performed):		
44340	(a) resection of bone or joint;		
	(b) excision of neuroma;		
	(c) skin cover with homodigital flaps		
	(H) (Anaes.) (Assist.)		
	<b>Fee:</b> \$264.25 <b>Benefit:</b> 75% = \$198.20		
	Amputation of 4 digits of one foot, distal to metatarsal head, including any of the following (if performed):		
	(a) resection of bone or joint;		
	(b) excision of neuroma;		
	(c) skin cover with homodigital flaps		
Amend	(H) (Anaes.) (Assist.)		
<b>Fee</b> 44350	<b>Fee:</b> \$299.85 <b>Benefit:</b> 75% = \$224.90		
	Amputation of 5 digits of one foot, distal to metatarsal head, including any of the following (if performed):		
	(a) resection of bone or joint;		
	(b) excision of neuroma;		
	(c) skin cover with homodigital flaps		
Amend	(H) (Anaes.) (Assist.)		
Fee 44354	<b>Fee:</b> \$343.20 <b>Benefit:</b> 75% = \$257.40		
	Amputation of one ray of one foot, proximal to the metatarsal head, including any of the following (if performed):		
	(a) resection of bone;		
	(b) excision of neuromas;		
	(c) skin cover or recontouring with homodigital flaps		
Amend	(H) (Anaes.) (Assist.)		
Fee 44358	<b>Fee:</b> \$228.85 <b>Benefit:</b> 75% = \$171.65		
	Amputation of one or more toes of one foot, or amputation at midfoot or hindfoot of one foot, for diabetic or other microvascular disease;		
	(a) including any of the following (if performed):		
<b>Amend</b> Fee 44359	(i) resection of bone;		

T8. SUR	RGICAL OPERATIONS	12. AMPUTATIONS
	(ii) excision of neuromas;	
	(iii) excision of one or more bones of the	foot;
	(iv) treatment of underlying infection;	
	(v) skin cover or recontouring with homo	digital flaps; and
	(b) excluding aftercare;	
	-applicable only once per foot per occasion or	n which the service is performed (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$274.60 <b>Benefit:</b> 75% = \$205.95	
	Amputation of foot, at ankle or hindfoot, inclu-	ding any of the following (if performed):
	(a) resection of bone;	
	(b) excision of neuromas;	
	(c) skin cover;	
Amend	(H) (Anaes.) (Assist.)	
<b>Fee</b> 44361	<b>Fee:</b> \$454.10 <b>Benefit:</b> 75% = \$340.60	
	Amputation of foot, transtarsal, including any o	f the following (if performed):
	(a) resection of bone;	
	(b) excision of neuromas;	
	(c) skin cover;	
Amend	(H) (Anaes.) (Assist.)	
<b>Fee</b> 44364	<b>Fee:</b> \$307.70 <b>Benefit:</b> 75% = \$230.80	
	AMPUTATION THROUGH THIGH, AT KNR	EE OR BELOW KNEE (Anaes.) (Assist.)
<b>Fee</b> 44367	<b>Fee:</b> \$543.10 <b>Benefit:</b> 75% = \$407.35	
Ess	AMPUTATION AT HIP (Anaes.) (Assist.)	
<b>Fee</b> 44370	<b>Fee:</b> \$749.40 <b>Benefit:</b> 75% = \$562.05	
_	HINDQUARTER, amputation of (Anaes.) (Assist.)	
<b>Fee</b> 44373	<b>Fee:</b> \$1,538.30 <b>Benefit:</b> 75% = \$1153.75	85% = \$1453.60
	AMPUTATION STUMP, reamputation of, to p	provide adequate skin and muscle cover (Assist.)
44376	Derived Fee: 75% of the original amputation fee	
T8. SUR	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Group T8. Surgical Operations	
	Subgroup 13. Plas	tic And Reconstructive Surgery

T8. SUR	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	GENERAL		
Fee	Single stage local muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals not in association with any of items 31356 to 31376 (Anaes.)		
45000	<b>Fee:</b> \$563.25 <b>Benefit:</b> 75% = \$422.45 85% = \$478.80		
	Single stage local myocutaneous flap repair to one defect, simple and small not in association with any of items 31356 to 31376 (Anaes.)		
<b>Fee</b> 45003	Fee:         \$626.05         Benefit:         75% = \$469.55         85% = \$541.35           Extended Medicare Safety Net Cap:         \$500.85		
F	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.) (Assist.)		
<b>Fee</b> 45006	<b>Fee:</b> \$1,079.70 <b>Benefit:</b> 75% = \$809.80		
	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.)		
Fee 45009	<b>Fee:</b> \$394.40 <b>Benefit:</b> 75% = \$295.80		
	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.) (Assist.)		
Fee 45012	<b>Fee:</b> \$660.75 <b>Benefit:</b> 75% = \$495.60		
	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.)		
Fee 45015	<b>Fee:</b> \$312.95 <b>Benefit:</b> 75% = \$234.75		
	Dermis, dermofat or fascia graft (other than transfer of fat by injection):		
	(a) if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items 51011 to 51171; and		
	(b) other than a service associated with a service to which item 39615, 39715, 40106 or 40109 applies (Anaes.) (Assist.)		
Fee 45018	<b>Fee:</b> \$492.85 <b>Benefit:</b> 75% = \$369.65 85% = \$418.95		
	Full face chemical peel for severely sun-damaged skin, if:		
	(a) the damage affects at least 75% of the facial skin surface area; and		
	(b) the damage involves photo-damage (dermatoheliosis); and		
	(c) the photo-damage involves:		
	(i) a solar keratosis load exceeding 30 individual lesions; or		
	(ii) solar lentigines; or		
	(iii) freckling, yellowing or leathering of the skin; or		
	(iv) solar kertoses which have proven refractory to, or recurred following, medical therapies; and		
Tee	(d) at least medium depth peeling agents are used; and		
<b>Fee</b> 45019	(e) the chemical peel is performed in the operating theatre of a hospital by a medical practitioner		

T8. SUF	RGICAL OPERATIO	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	recognised as a sp	ecialist in the specialty of dermatology or plastic surgery.
	Applicable once o	only in any 12 month period (Anaes.)
	Fee: \$412.80	<b>Benefit:</b> 75% = \$309.60
	ABRASIVE THE to 1 aesthetic area	RAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited (Anaes.)
<b>Fee</b> 45021	(See para TN.8.91 o <b>Fee:</b> \$184.55	f explanatory notes to this Category) Benefit: $75\% = $138.45$ $85\% = $156.90$
	ABRASIVE THE than 1 aesthetic ar	RAPY for severely disfiguring scarring resulting from trauma, burns or acne - more ea (Anaes.)
<b>Fee</b> 45024	(See para TN.8.91 o <b>Fee:</b> \$414.70	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$311.05 85% = \$352.50
		DE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing a for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aes.)
<b>Fee</b> 45025	Fee: \$184.55	f explanatory notes to this Category) Benefit: 75% = \$138.45 85% = \$156.90 are Safety Net Cap: \$147.65
		DE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing c for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aes.)
<b>Fee</b> 45026	Fee: \$414.70	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$311.05 85% = \$352.50 <b>are Safety Net Cap:</b> \$331.80
	ANGIOMA, caute (Anaes.)	erisation of or injection into, where undertaken in the operating theatre of a hospital
Fee 45027	Fee: \$125.25	<b>Benefit:</b> 75% = \$93.95 85% = \$106.50
		nangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial or mucous surface, small, excision and suture of (Anaes.)
Fee 45030	Fee: \$134.45	<b>Benefit:</b> 75% = \$100.85 85% = \$114.30
	ANGIOMA, (haei	mangioma or lymphangioma or both), large or involving deeper tissue including facial excision and suture of (Anaes.)
<b>Fee</b> 45033	<b>Fee:</b> \$250.45	<b>Benefit:</b> 75% = \$187.85 85% = \$212.90
	ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.)	
<b>Fee</b> 45035	Fee: \$730.50	<b>Benefit:</b> 75% = \$547.90
-5033		nangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.)
Fee	x	
45036	<b>Fee:</b> \$1,173.75	<b>Benefit:</b> 75% = \$880.35
T	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.)	
Fee		

T8. SUF	GICAL OPERATION	S 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
_	ARTERIOVENOUS	MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.)	
<b>Fee</b> 45042	Fee: \$320.90	<b>Benefit:</b> 75% = \$240.70 85% = \$272.80	
-	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.)		
<b>Fee</b> 45045	Fee: \$320.90	<b>Benefit:</b> 75% = \$240.70 85% = \$272.80	
_		DUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or jor excision of (Anaes.) (Assist.)	
<b>Fee</b> 45048	Fee: \$805.95	<b>Benefit:</b> 75% = \$604.50	
	Contour reconstructio	n by open repair of contour defects, due to deformity, if:	
		tive surgery is indicated because the deformity is secondary to congenital absence from trauma (other than trauma from previous cosmetic surgery); and	
	(b) insertion of a non-	biological implant is required, other than one or more of the following:	
	(i) insertion of a non-biological implant that is a component of another service specified in Group T8;		
	(ii) injection of l	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.)		
<b>Fee</b> 45051	Fee: \$492.95	<b>Benefit:</b> 75% = \$369.75	
	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.)		
<b>Fee</b> 45054		planatory notes to this Category) Benefit: 75% = \$192.10	
	Developmental breast	abnormality, single stage correction of, if:	
	(a) the correction invo	plves either:	
	(i) bilateral mast	topexy 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/ documented in the par	or diagnostic imaging evidence demonstrating the clinical need for this service is tient notes	
_	Applicable only once	per occasion on which the service is provided (Anaes.) (Assist.)	
Fee 45060	Fee: \$1,322.80	<b>Benefit:</b> 75% = \$992.10	

T8. SUF	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	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.	
Ess	Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)	
<b>Fee</b> 45061	<b>Fee:</b> \$1,322.80 <b>Benefit:</b> 75% = \$992.10	
	Developmental breast abnormality, 2 stage correction of, second stage, involving surgery on both breasts with a combination of exchange of one or more tissue expanders for one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if:	
	(a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least:	
	(i) 20% in normally shaped breasts; or	
	(ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and	
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes.	
Fee	Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)	
45062	<b>Fee:</b> \$957.25 <b>Benefit:</b> 75% = \$717.95	
	SKIN FLAP SURGERY	
	Single stage local flap, if indicated to repair one defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.)	
<b>Fee</b> 45200	(See para TN.8.93 of explanatory notes to this Category)         Fee: \$295.90       Benefit: 75% = \$221.95       85% = \$251.55         Extended Medicare Safety Net Cap: \$236.75	
	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion (only in association with items 31000, 31001, 31002, 31003, 31004, 31005, 31358, 31359, 31360, 31363, 31364, 31369, 31370, 31371, 31373 or 31376)-may be claimed only once per defect (Anaes.)	
<b>Fee</b> 45201	(See para TN.8.93 of explanatory notes to this Category) <b>Fee:</b> \$430.70 <b>Benefit:</b> 75% = \$323.05 85% = \$366.10	
<b>Fee</b> 45202	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion in a patient, if the clinical relevance of the procedure is clearly annotated in the patient's record and either:	

T8. SUR	GICAL OPERATIO	DNS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(a) item 45201	applies and additional flap repair is required for the same defect; or
	(b) item 45201	does not apply and either:
	(i) the patient	t has severe pre-existing scarring, severe skin atrophy or sclerodermoid changes; or
	(ii) the repair is contiguous with a free margin (Anaes.)	
	(See para TN.8.93, 7 <b>Fee:</b> \$430.70	IN.8.126 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$323.05 85% = \$366.10
		flap, if indicated to repair one defect, complicated or large, excluding flap for male nd excluding H-flap or double advancement flap not in association with any of items Anaes.) (Assist.)
<b>Fee</b> 45203	Fee: \$422.50	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$316.90 85% = \$359.15 <b>tre Safety Net Cap:</b> \$338.00
		flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, and excluding H-flap or double advancement flap not in association with any of items Anaes.)
<b>Fee</b> 45206	Fee: \$399.10	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$299.35 85% = \$339.25 <b>are Safety Net Cap:</b> \$319.30
Fee		dvancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead not any of items 31356 to 31376 (Anaes.)
45207	Fee: \$399.10	<b>Benefit:</b> 75% = \$299.35 85% = \$339.25
Fee	DIRECT FLAP R	EPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.)
45209	Fee: \$492.95	<b>Benefit:</b> 75% = \$369.75 85% = \$419.05
Fee	DIRECT FLAP R	EPAIR (cross arm, abdominal or similar), second stage (Anaes.)
45212	Fee: \$244.60	<b>Benefit:</b> 75% = \$183.45 85% = \$207.95
	DIRECT FLAP R	EPAIR, cross leg, first stage (Anaes.) (Assist.)
Fee 45215	Fee: \$1,055.10	<b>Benefit:</b> 75% = \$791.35
	DIRECT FLAP R	EPAIR, cross leg, second stage (Anaes.) (Assist.)
Fee 45218	<b>Fee:</b> \$473.30	<b>Benefit:</b> 75% = \$355.00
	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.)	
<b>Fee</b> 45221	Fee: \$272.20	<b>Benefit:</b> 75% = \$204.15 85% = \$231.40
	<b>Fee:</b> $52/2.20$ <b>Definit:</b> $75\% = 5204.15$ $85\% = 5251.40$ DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.)	
Fee	Fee: \$122.35       Benefit: 75% = \$91.80       85% = \$104.00	
45224		P OR TUBED PEDICLE, formation of (Anaes.) (Assist.)
<b>Fee</b> 45227	<b>Fee:</b> \$463.50	Benefit: 75% = \$347.65 85% = \$394.00
		IRECT FLAP OR TUBED PEDICLE, delay of (Anaes.)
Fee		

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
_	INDIRECT FLAP OR TUBED site (Anaes.) (Assist.)	PEDICLE, preparation of intermediate or final site and attachment to the
Fee 45233	<b>Fee:</b> \$492.95 <b>Benefit:</b> 7	75% = \$369.75 85% = \$419.05
	INDIRECT FLAP OR TUBED	PEDICLE, spreading of pedicle, as a separate procedure (Anaes.)
Fee 45236	<b>Fee:</b> \$386.55 <b>Benefit:</b> 7	25% = \$289.95
	DIRECT, INDIRECT OR LOC which item 45240 applies (Ana	CAL FLAP, revision of, by incision and suture, not being a service to es.)
Fee 45239	<b>Fee:</b> \$272.20 <b>Benefit:</b> 7	75% = \$204.15 85% = \$231.40
	DIRECT, INDIRECT OR LOC 45239, 45497, 45498 or 45499	CAL FLAP, revision of, by liposuction, not being a service to which item applies (Anaes.)
Fee 45240	<b>Fee:</b> \$272.20 <b>Benefit:</b> 7	25% = \$204.15 85% = \$231.40
		FREE GRAFTS
	FREE GRAFTING (split skin)	of a granulating area, small (Anaes.)
Fee 45400	<b>Fee:</b> \$213.00 <b>Benefit:</b> 7	75% = \$159.75  85% = \$181.05
		of a granulating area, extensive (Anaes.) (Assist.)
<b>Fee</b> 45403	Fee: \$424.00 Benefit: 7	75% = \$318.00 85% = \$360.40
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (Anaes.) (Assist.)	
<b>Fee</b> 45406	(See para TN.8.94 of explanatory r Fee: \$469.35 Benefit: 7	notes to this Category) 25% = \$352.05 85% = \$398.95
	FREE GRAFTING (split skin) but less than 6 per cent of total	to burns, including excision of burnt tissue - involving 3 per cent or more body surface (Anaes.) (Assist.)
<b>Fee</b> 45409	(See para TN.8.94 of explanatory notes to this Category) <b>Fee:</b> \$626.05 <b>Benefit:</b> 75% = \$469.55	
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (Anaes.) (Assist.)	
<b>Fee</b> 45412	(See para TN.8.94 of explanatory notes to this Category) <b>Fee:</b> \$860.85 <b>Benefit:</b> 75% = \$645.65	
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 9 per cent or more but less than 12 per cent of total body surface (Anaes.) (Assist.)	
<b>Fee</b> 45415	(See para TN.8.94 of explanatory notes to this Category) 5 <b>Fee:</b> \$938.85 <b>Benefit:</b> 75% = \$704.15	
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 12 per cent or more but less than 15 per cent of total body surface (Anaes.) (Assist.)	
<b>Fee</b> 45418	(See para TN.8.94 of explanatory notes to this Category) <b>Fee:</b> \$1,017.15 <b>Benefit:</b> 75% = \$762.90	
	FREE GRAFTING (split skin)	to 1 defect, including elective dissection, small (Anaes.)
Fee	<b>Fee:</b> \$295.90 <b>Benefit:</b> 7	75% = \$221.95 85% = \$251.55

T8. SUF	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGE	RY	
	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.)		
Fee 45442	<b>Fee:</b> \$610.30 <b>Benefit:</b> 75% = \$457.75 85% = \$525.60		
-	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of, and removal of mould) (Anaes.) (Assist.)		
Fee 45445	<b>Fee:</b> \$579.15 <b>Benefit:</b> 75% = \$434.40 85% = \$494.45		
_	FREE GRAFTING (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes.)	,	
Fee 45448	<b>Fee:</b> \$391.25 <b>Benefit:</b> 75% = \$293.45 85% = \$332.60		
_	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.)		
Fee 45451	<b>Fee:</b> \$492.95 <b>Benefit:</b> 75% = \$369.75 85% = \$419.05		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - one surgeon (Anaes.) (Assist.)		
Fee 45460	<b>Fee:</b> \$1,304.10 <b>Benefit:</b> 75% = \$978.10		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)		
Fee 45461	<b>Fee:</b> \$929.45 <b>Benefit:</b> 75% = \$697.10		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - conjoint surgery, co- surgeon (Assist.)		
Fee 45462	<b>Fee:</b> \$701.35 <b>Benefit:</b> 75% = \$526.05		
F	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - one surgeon (Anaes.) (Assist.)		
Fee 45464	<b>Fee:</b> \$1,990.60 <b>Benefit:</b> 75% = \$1492.95		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)		
Fee 45465	<b>Fee:</b> \$1,418.20 <b>Benefit:</b> 75% = \$1063.65 85% = \$1333.50		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - conjoint surgery, co-surgeon (Assist.)		
Fee 45466	<b>Fee:</b> \$1,069.60 <b>Benefit:</b> 75% = \$802.20 85% = \$984.90		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 30 percent or more but less than 40 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)		
Fee 45468	<b>Fee:</b> \$1,906.90 <b>Benefit:</b> 75% = \$1430.20		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 30 percent or more but less than 40 percent of total body surface - conjoint surgery, co-surgeon (Assist.)		
Fee 45469	<b>Fee:</b> \$1,438.70 <b>Benefit:</b> 75% = \$1079.05 85% = \$1354.00		
Fee	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 40 percent or		

T8. SUF		S 13. PLASTIC AND RECONSTRUCTIVE SURGERY
45471	more but less than 50 (Assist.)	<i>) percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.)
	Fee: \$2,397.00	<b>Benefit:</b> 75% = \$1797.75 85% = \$2312.30
		split skin) to burns, including excision of burnt tissue - involving 40 percent or 0 percent of total body surface - conjoint surgery, co-surgeon (Assist.)
Fee 45472	Fee: \$1,808.05	<b>Benefit:</b> 75% = \$1356.05 85% = \$1723.35
	FREE GRAFTING (	split skin) to burns, including excision of burnt tissue - involving 50 percent or <i>percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.)
Fee 45474	Fee: \$2,885.65	<b>Benefit:</b> 75% = \$2164.25 85% = \$2800.95
	FREE GRAFTING (	split skin) to burns, including excision of burnt tissue - involving 50 percent or <i>percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.)
Fee 45475	Fee: \$2,177.25	<b>Benefit:</b> 75% = \$1632.95 85% = \$2092.55
		split skin) to burns, including excision of burnt tissue - involving 60 percent or 0 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)
Fee 45477	Fee: \$3,374.40	<b>Benefit:</b> 75% = \$2530.80 85% = \$3289.70
	FREE GRAFTING (	split skin) to burns, including excision of burnt tissue - involving 60 percent or 0 percent of total body surface - conjoint surgery, co-surgeon (Assist.)
Fee 45478	Fee: \$2,545.20	<b>Benefit:</b> 75% = \$1908.90 85% = \$2460.50
	FREE GRAFTING (	split skin) to burns, including excision of burnt tissue - involving 70 percent or <i>percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.)
Fee 45480	Fee: \$3,863.05	<b>Benefit:</b> 75% = \$2897.30 85% = \$3778.35
	FREE GRAFTING (	split skin) to burns, including excision of burnt tissue - involving 70 percent or D percent of total body surface - conjoint surgery, co-surgeon (Assist.)
Fee 45481	Fee: \$2,914.60	<b>Benefit:</b> 75% = \$2185.95 85% = \$2829.90
	FREE GRAFTING (	split skin) to burns, including excision of burnt tissue - involving 80 percent or urface - conjoint surgery, principal surgeon (Anaes.) (Assist.)
Fee 45483	Fee: \$4,401.35	<b>Benefit:</b> 75% = \$3301.05 85% = \$4316.65
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, co-surgeon (Assist.)	
<b>Fee</b> 45484		<b>Benefit:</b> 75% = \$2490.60 85% = \$3236.10
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes.) (Assist.)	
Fee 45485	<b>Fee:</b> \$549.10	<b>Benefit:</b> 75% = \$411.85
-	FREE GRAFTING (	split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior hin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.)
Fee 45486	<b>Fee:</b> \$469.35	<b>Benefit:</b> 75% = \$352.05

T8. SUF	GICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
F	FREE GRAFTIN (Assist.)	G (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.)	
<b>Fee</b> 45487	Fee: \$422.50	<b>Benefit:</b> 75% = \$316.90 85% = \$359.15	
	FREE GRAFTIN hand (Anaes.) (As	G (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the ssist.)	
Fee 45488	Fee: \$469.35	<b>Benefit:</b> 75% = \$352.05	
		G (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the	
<b>Fee</b> 45489	Fee: \$704.25	<b>Benefit:</b> 75% = \$528.20 85% = \$619.55	
Fee	FREE GRAFTIN hand (Anaes.) (As	G (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the ssist.)	
<b>гее</b> 45490	Fee: \$939.10	<b>Benefit:</b> 75% = \$704.35	
	FREE GRAFTIN hand (Anaes.) (As	G (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the ssist.)	
<b>Fee</b> 45491	Fee: \$1,173.75	<b>Benefit:</b> 75% = \$880.35	
		G (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the ssist.)	
<b>Fee</b> 45492	Fee: \$1,408.45	<b>Benefit:</b> 75% = \$1056.35	
		G (split skin) to burns, including excision of burnt tissue - portion of digit of hand	
<b>Fee</b> 45493	<b>Fee:</b> \$422.50	<b>Benefit:</b> 75% = \$316.90	
	FREE GRAFTIN ears) (Anaes.) (As	G (split skin) to burns, including excision of burnt tissue - whole of face (excluding ssist.)	
<b>Fee</b> 45494	Fee: \$1,705.05	<b>Benefit:</b> 75% = \$1278.80 85% = \$1620.35	
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES		
Б	FLAP, free tissue	transfer using microvascular techniques - revision of, by open operation (Anaes.)	
<b>Fee</b> 45496	Fee: \$432.90	<b>Benefit:</b> 75% = \$324.70	
	FLAP, free tissue transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>complete revision of</i> , by liposuction (Anaes.)		
<b>Fee</b> 45497	Fee: \$338.10	<b>Benefit:</b> 75% = \$253.60	
	FLAP, free tissue transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>staged revision of</i> , by liposuction - first stage (Anaes.)		
<b>Fee</b> 45498	<b>Fee:</b> \$272.20 <b>Benefit:</b> 75% = \$204.15		
	FLAP, free tissue transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>staged revision of</i> , by liposuction - second stage (Anaes.)		
<b>Fee</b> 45499	Fee: \$202.85	<b>Benefit:</b> 75% = \$152.15	
<b>Fee</b> 45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.)		

T8. SURGICAL OPERATIONS		DNS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Fee: \$1,134.50	<b>Benefit:</b> 75% = \$850.90
	MICROVASCUL limb or digit (Ana	AR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of es.) (Assist.)
Fee 45501	Fee: \$1,846.60	<b>Benefit:</b> 75% = \$1384.95
	MICROVASCUL limb or digit (Ana	AR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of es.) (Assist.)
Fee 45502	Fee: \$1,846.60	<b>Benefit:</b> 75% = \$1384.95
	MICRO-ARTERI	AL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.)
Fee 45503	Fee: \$2,112.65	<b>Benefit:</b> 75% = \$1584.50
		AR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of etting in of free flap (Anaes.) (Assist.)
<b>Fee</b> 45504	Fee: \$1,846.60	<b>Benefit:</b> 75% = \$1384.95
		AR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of etting in of free flap (Anaes.) (Assist.)
Fee 45505	Fee: \$1,846.60	<b>Benefit:</b> 75% = \$1384.95
		neck, not more than 3 cm in length, revision of, where undertaken in the operating al, or where performed by a specialist in the practice of his or her specialty (Anaes.)
<b>Fee</b> 45506	(See para TN.8.95 o <b>Fee:</b> \$228.85	f explanatory notes to this Category) <b>Benefit:</b> $75\% = \$171.65$ $85\% = \$194.55$
		neck, more than 3 cm in length, revision of, where undertaken in the operating theatre here performed by a specialist in the practice of his or her specialty (Anaes.)
<b>Fee</b> 45512	(See para TN.8.95 o <b>Fee:</b> \$307.70	f explanatory notes to this Category) <b>Benefit:</b> $75\% = $230.80$ $85\% = $261.55$
	SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or where performed by a specialist in the practice of his or her specialty (Anaes.)	
<b>Fee</b> 45515	(See para TN.8.95 o <b>Fee:</b> \$194.10	f explanatory notes to this Category) <b>Benefit:</b> $75\% = $145.60$ $85\% = $165.00$
	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her speciality (Anaes.)	
<b>Fee</b> 45518	(See para TN.8.95 o <b>Fee:</b> \$234.85	f explanatory notes to this Category) Benefit: $75\% = \$176.15$ $85\% = \$199.65$
	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.)	
<b>Fee</b> 45519	Fee: \$446.45	<b>Benefit:</b> 75% = \$334.85
		aplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer abnormality of the breast (Anaes.) (Assist.)
<b>Fee</b> 45520	Fee: \$936.90	<b>Benefit:</b> 75% = \$702.70

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Reduction mammaplasty (unilateral) wi	thout surgical repositioning of the nipple:	
	(a) excluding the treatment of gynaecon	nastia; and	
	(b) not with insertion of any prosthesis (Anaes.) (Assist.)		
Fee 45522	<b>Fee:</b> \$657.35 <b>Benefit:</b> 75% = \$49	93.05	
	Reduction mammaplasty (bilateral) with	n surgical repositioning of the nipple:	
	(a) for patients with macromastia and ex	speriencing pain in the neck or shoulder region; and	
	(b) not with insertion of any prosthesis	(Anaes.) (Assist.)	
Fee 45523	<b>Fee:</b> \$1,405.45 <b>Benefit:</b> 75% = \$10	054.10	
	Mammaplasty, augmentation (unilatera	) in the context of:	
	(a) breast cancer; or		
	(b) developmental abnormality of the br an appropriate volumetric measurement	reast, if there is a difference in breast volume, as demonstrated by technique, of at least:	
	(i) 20% in normally shaped breast	s; or	
	(ii) 10% in tubular breasts or in br	easts with abnormally high inframammary folds.	
	Applicable only once per occasion on w	hich the service is provided (Anaes.) (Assist.)	
<b>Fee</b> 45524	(See para TN.8.96 of explanatory notes to th <b>Fee:</b> \$771.70 <b>Benefit:</b> 75% = \$57		
	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis (Anaes.) (Assist.)		
<b>Fee</b> 45527	(See para TN.8.96 of explanatory notes to th <b>Fee:</b> \$771.70 <b>Benefit:</b> 75% = \$57		
	Mammaplasty, augmentation, bilateral	other than a service to which item 45527 applies), if:	
	(a) reconstructive surgery is indicated b	ecause of:	
	(i) developmental malformation of	f breast tissue (excluding hypomastia); or	
(ii) disease of or trauma to the breast (other than trauma resulting from previous o surgery); or		ast (other than trauma resulting from previous elective cosmetic	
	(iii) amastia secondary to a congenital endocrine disorder; and		
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for documented in the patient notes (Anaes.) (Assist.)		
<b>Fee</b> 45528	(See para TN.8.96 of explanatory notes to th <b>Fee:</b> \$1,157.40 <b>Benefit:</b> 75% = \$80		
<b>Fee</b> 45530	including repair of secondary skin defect	a latissimus dorsi or other large muscle or myocutaneous flap, et, if required, excluding repair of muscular aponeurotic layer, rvice to which item 30165, 30168, 30171, 30172, 30176, 30177	

T8. SUR	URGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE	SURGERY	
	(H) (Anaes.) (Assist.)		
	(See para TN.8.97 of explanatory notes to this Category) <b>Fee:</b> \$1,143.95 <b>Benefit:</b> 75% = \$858.00		
	BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other sim procedure (Anaes.) (Assist.)		
<b>Fee</b> 45533	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> $$1,295.50$ <b>Benefit:</b> $75\% = $971.65$		
Fee	BREAST RECONSTRUCTION using breast sharing technique (second stage) including dipedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaest		
45536	<b>Fee:</b> \$476.45 <b>Benefit:</b> 75% = \$357.35		
_	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (A		
Fee 45539	<b>Fee:</b> \$1,114.65 <b>Benefit:</b> 75% = \$836.00		
Fee	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.)	- removal of	
45542	<b>Fee:</b> \$638.25 <b>Benefit:</b> 75% = \$478.70		
	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist	st.)	
<b>Fee</b> 45545	(See para TN.8.100 of explanatory notes to this Category) <b>Fee:</b> \$647.80 <b>Benefit:</b> 75% = \$485.85 85% = \$563.10 <b>Extended Medicare Safety Net Cap:</b> \$518.25		
	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction mastectomy or for congenital absence of nipple	after	
<b>Fee</b> 45546	(See para TN.8.100 of explanatory notes to this Category) <b>Fee:</b> \$205.85 <b>Benefit:</b> 75% = \$154.40 85% = \$175.00		
F	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.)		
Fee 45548	<b>Fee:</b> \$288.00 <b>Benefit:</b> 75% = \$216.00 85% = \$244.80		
	Breast prosthesis, removal of, with excision of at least half of the fibrous capsule, not with i any prosthesis. The excised specimen must be sent for histopathology and the volume remo documented in the histopathology report (Anaes.) (Assist.)		
<b>Fee</b> 45551	(See para TN.8.167 of explanatory notes to this Category) <b>Fee:</b> \$461.65 <b>Benefit:</b> 75% = \$346.25		
	Breast prosthesis, removal of and replacement with another prosthesis, following medical co (for rupture, migration of prosthetic material or symptomatic capsular contracture), if:	omplications	
	(a) either:		
	(i) it is demonstrated by intra-operative photographs post-removal that removal alone unacceptable deformity; or	would cause	
	(ii) the original implant was inserted in the context of breast cancer or developmental and	abnormality;	
<b>Fee</b> 45553	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for thi	s service is	

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	documented in the patient notes (Ana	es.) (Assist.)
	(See para TN.8.98 of explanatory notes to <b>Fee:</b> \$594.75 <b>Benefit:</b> 75% = \$	
	(for rupture, migration of prosthetic n	ement with another prosthesis, following medical complications naterial or symptomatic capsular contracture), including excision of formation of a new pocket, or both, if:
	(a) either:	
	(i) it is demonstrated by intra-op unacceptable deformity; or	perative photographs post-removal that removal alone would cause
	(ii) the original implant was inseand	erted in the context of breast cancer or developmental abnormality;
	(b) the excised specimen is sent for h histopathology report; and	istopathology and the volume removed is documented in the
	(c) photographic and/or diagnostic im documented in the patient notes (Ana	aging evidence demonstrating the clinical need for this service is es.) (Assist.)
<b>Fee</b> 45554	(See para TN.8.98 of explanatory notes to <b>Fee:</b> \$727.80 <b>Benefit:</b> 75% = \$	
	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 or	which the service is provided (Anaes.) (Assist.)
<b>Fee</b> 45556	(See para TN.8.99 of explanatory notes to <b>Fee:</b> \$797.05 <b>Benefit:</b> 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.)
<b>Fee</b> 45558	(See para TN.8.99 of explanatory notes to <b>Fee:</b> \$1,195.50 <b>Benefit:</b> 75% = \$	
		e treatment of alopecia of congenital or traumatic origin or due to ess, not being a service to which another item in this Group applies
<b>Fee</b> 45560	Fee: \$492.85Benefit: 75% = 5Extended Medicare Safety Net Cap	\$369.65

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
Faa	MICROVASCULAR ANASTO supercharging of pedicled flaps (	MOSIS of artery or vein using microsurgical techniques, for Anaes.) (Assist.)
<b>Fee</b> 45561	<b>Fee:</b> \$1,846.60 <b>Benefit:</b> 75	% = \$1384.95
_	FREE TRANSFER OF TISSUE involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)	
Fee 45562	<b>Fee:</b> \$1,143.95 <b>Benefit:</b> 75	% = \$858.00 85% = \$1059.25
F		FLAP, including direct repair of secondary cutaneous defect if le pattern baldness (Anaes.) (Assist.)
<b>Fee</b> 45563	<b>Fee:</b> \$1,143.95 <b>Benefit:</b> 75	% = \$858.00 85% = \$1059.25
	deformity, surgery or trauma, inv and including raising of tissue or transfer of tissue, insetting of tiss performed, other than a service a	tive surgery for the repair of major tissue defect due to congenital volving anastomoses of up to 2 vessels using microvascular techniques a vascular or neurovascular pedicle, preparation of recipient vessels, sue at recipient site and direct repair of secondary cutaneous defect if ssociated with a service to which item 30165, 30168, 30171, 30172, 502, 45504, 45505 or 45562 applies-conjoint surgery, principal Assist.)
<b>Fee</b> 45564	(See para TN.8.8 of explanatory note Fee: \$2,649.50 Benefit: 75	es to this Category) % = \$1987.15
	deformity, surgery or trauma, inv and including raising of tissue or transfer of tissue, insetting of tiss performed, other than a service a	tive surgery for the repair of major tissue defect due to congenital volving anastomoses of up to 2 vessels using microvascular techniques a vascular or neurovascular pedicle, preparation of recipient vessels, sue at recipient site and direct repair of secondary cutaneous defect if ssociated with a service to which item 30165, 30168, 30171, 30172, 502, 45504, 45505 or 45562 applies-conjoint surgery, conjoint specialist
<b>Fee</b> 45565	(See para TN.8.8 of explanatory note Fee: \$1,987.20 Benefit: 75	es to this Category) % = \$1490.40
Fee	expansion unit and all attendance	g a service to which item 45539 or 45542 applies - insertion of tissue es for subsequent expansion injections (Anaes.) (Assist.)
45566	<b>Fee:</b> \$1,114.65 <b>Benefit:</b> 75	
<b>Fee</b> 45568	TISSUE EXPANDER, removal of         Fee: \$461.65       Benefit: 75	of, with complete excision of fibrous capsule (Anaes.) (Assist.) % = \$346.25
F		TH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, tems 45562, 45564, 45565 or 45530 (Anaes.) (Assist.)
<b>Fee</b> 45569	<b>Fee:</b> \$705.10 <b>Benefit:</b> 75	% = \$528.85
	CLOSURE OF ABDOMEN, rep 45569 (Anaes.) (Assist.)	air of musculoaponeurotic layer, being a service associated with item
<b>Fee</b> 45570	<b>Fee:</b> \$952.05 <b>Benefit:</b> 75	% = \$714.05 85% = \$867.35
<b>Fee</b> 45572		EXPANSION performed during an operation when combined with a Group T8 applies including expansion injections and excluding ss (Anaes.)

T8. SUF	GICAL OPERAT	IONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$303.50	<b>Benefit:</b> 75% = \$227.65	85% = \$258.00	
	FACIAL NERV	E PARALYSIS, free fascia	graft for (Anaes.) (Assist.)	
<b>Fee</b> 45575	<b>Fee:</b> \$749.40	<b>Benefit:</b> 75% = \$562.05	85% = \$664.70	
	FACIAL NERV	E PARALYSIS, muscle tran	sfer for (Anaes.) (Assist.)	
<b>Fee</b> 45578	Fee: \$867.85	<b>Benefit:</b> 75% = \$650.90		
_	FACIAL NERV	E PALSY, excision of tissue	e for (Anaes.)	
<b>Fee</b> 45581	Fee: \$288.00	<b>Benefit:</b> 75% = \$216.00	85% = \$244.80	
	traumatic pseudo		e regional area (one limb or trunk), for treatment of post /or diagnostic imaging evidence demonstrating the clinical tient notes (Anaes.)	
<b>Fee</b> 45584	(See para TN.8.8, 7 <b>Fee:</b> \$657.35	FN.8.101 of explanatory notes <b>Benefit:</b> 75% = \$493.05	to this Category)	
		tion assisted lipolysis) to one service to which item 3152	e regional area (one limb or trunk), other than a service 5 applies, if:	
	(a) the liposuction is for:			
	(i) the treatment of Barraquer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or			
	(ii) the reduction of a buffalo hump that is secondary to an endocrine disorder or pharmacological treatment of a medical condition; and			
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)			
<b>Fee</b> 45585	(See para TN.8.8, 7 <b>Fee:</b> \$657.35	ΓΝ.8.101 of explanatory notes <b>Benefit:</b> 75% = \$493.05	to this Category)	
	Meloplasty for co	prrection of facial asymmetr	y if:	
		y is secondary to trauma (in n (such as facial nerve palsy	cluding previous surgery), a congenital condition or a (); and	
	(b) the meloplast	y is limited to one side of th	e face (Anaes.) (Assist.)	
Fee(See para TN.8.102 of explanatory notes to this Category)45587Fee: \$926.95Benefit: 75% = \$695.25		ategory)		
	Meloplasty (excl	uding browlifts and chinlift	platysmaplasties), bilateral, if:	
	(a) surgery is indicated to correct a functional impairment due to a congenital condition, disease (excluding post-acne scarring) or trauma (other than trauma resulting from previous elective cosmetic surgery); and			
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)			
<b>Fee</b> 45588	(See para TN.8.10) <b>Fee:</b> \$1,390.55	2 of explanatory notes to this C Benefit: 75% = \$1042.95		
<b>Fee</b> 45590	ORBITAL CAV	ITY, reconstruction of a wal	ll or floor, with or without foreign implant (Anaes.) (Assist.)	

T8. SUR	GICAL OPERAT	IONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$502.85	<b>Benefit:</b> 75% = \$377.15	
		ITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or contents (Anaes.) (Assist.)	
<b>Fee</b> 45593	Fee: \$590.65	<b>Benefit:</b> 75% = \$443.00	
	MAXILLA, tota	resection of (Anaes.) (Assist.)	
<b>Fee</b> 45596	Fee: \$936.90	<b>Benefit:</b> 75% = \$702.70	
	MAXILLA, tota	resection of both maxillae (Anaes.) (Assist.)	
<b>Fee</b> 45597	Fee: \$1,254.25	<b>Benefit:</b> 75% = \$940.70	
	MANDIBLE, to	al resection of both sides, including condylectomies where performed (Anaes.) (Assist.)	
Fee 45599	Fee: \$974.50	<b>Benefit:</b> 75% = \$730.90 85% = \$889.80	
	MANDIBLE, in	cluding lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.)	
Fee 45602	Fee: \$727.80	<b>Benefit:</b> 75% = \$545.85	
	MANDIBLE OF	MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.)	
Fee 45605	Fee: \$611.40	<b>Benefit:</b> 75% = \$458.55	
		mimandibular reconstruction with bone graft, not being a service associated with a	
Fee	service to which	item 45599 applies (Anaes.) (Assist.)	
45608	Fee: \$860.85	<b>Benefit:</b> 75% = \$645.65	
Fee	MANDIBLE, co	ndylectomy (Anaes.) (Assist.)	
45611	Fee: \$492.95	<b>Benefit:</b> 75% = \$369.75	
	EYELID, WHO (Assist.)	LE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.)	
<b>Fee</b> 45614	Fee: \$611.40 Extended Medi	<b>Benefit:</b> 75% = \$458.55 85% = \$526.70 care Safety Net Cap: \$489.15	
	Upper eyelid, re	luction of, if:	
	(a) the reduction	is for any of the following:	
	(i) skin redundancy that causes a visual field defect (confirmed by an optometrist or ophthalmologist) or intertriginous inflammation of the eyelid;		
	(ii) herniation of orbital fat in exophthalmos;		
	(iii) facial nerve palsy;		
	(iv) post-traumatic scarring;		
	<ul><li>(v) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions mentioned in subparagraphs (i) to (iv); and</li></ul>		
		and/or diagnostic imaging evidence demonstrating the clinical need for this service is ne patient notes (Anaes.)	
<b>Fee</b> 45617	(See para TN.8.10	3 of explanatory notes to this Category)	

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Fee: \$244.60Benefit: 75% = \$1Extended Medicare Safety Net Cap:	83.45 85% = \$207.95 \$195.70
	Lower eyelid, reduction of, if:	
	(a) the reduction is for:	
	(i) herniation of orbital fat in exo	phthalmos, facial nerve palsy or post-traumatic scarring; or
	(ii) the restoration of symmetry of conditions; and	f the contralateral lower eyelid in respect of one of these
	(b) photographic and/or diagnostic ima documented in the patient notes (Anae	ging evidence demonstrating the clinical need for this service is s.)
<b>Fee</b> 45620	(See para TN.8.103 of explanatory notes to Fee: \$339.25 Benefit: 75% = \$2 Extended Medicare Safety Net Cap:	254.45 85% = \$288.40
	Ptosis of upper eyelid (unilateral), corr	ection of, by:
	(a) sutured elevation of the tarsal plate aponeurosis); or	on the eyelid retractors (Muller's or levator muscle or levator
	(b) sutured suspension to the brow/from	ntalis muscle;
	Not applicable to a service for repair of mechanical ptosis to which item 45617 applies (Anaes.) (Assist.)	
<b>Fee</b> 45623	Fee: \$752.30 Benefit: 75% = \$5 Extended Medicare Safety Net Cap:	564.25 85% = \$667.60 \$601.85
	Ptosis of upper eyelid, correction of, b	y:
	(a) sutured elevation of the tarsal plate aponeurosis); or	on the eyelid retractors (Muller's or levator muscle or levator
	(b) sutured suspension to the brow/from	ntalis muscle;
	if a previous ptosis surgery has been pe	erformed on that side (Anaes.) (Assist.)
<b>Fee</b> 45624	Fee: \$975.40Benefit: 75% = \$7Extended Medicare Safety Net Cap:	
		height by revision of levator sutures within one week of primary nent, performed in the operating theatre of a hospital (Anaes.)
Fee 45625	<b>Fee:</b> \$195.15 <b>Benefit:</b> 75% = \$1	
	Ectropion or entropion, not caused by trachoma, correction of (unilateral) (Anaes.)	
Fee 45626		254.45 85% = \$288.40
	Ectropion or entropion, caused by track	ionia, concetion of (unnateral) (Anaes.)
<b>Fee</b> 45627 S		254.45  85% = \$288.40
		254.45 85% = \$288.40

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Rhinoplasty, partial, involving correct	ction of lateral or alar cartilages, if:
	(a) the indication for surgery is:	
	(i) airway obstruction and the p	patient has a self-reported NOSE Scale score of greater than 45; or
	(ii) significant acquired, congen	nital or developmental deformity; and
	(b) photographic and/or NOSE Scale documented in the patient notes (Ana	evidence demonstrating the clinical need for this service is nes.)
<b>Fee</b> 45632	(See para TN.8.104 of explanatory notes Fee: \$532.70 Benefit: 75% = Extended Medicare Safety Net Cap	\$399.55 85% = \$452.80
	Rhinoplasty, partial, involving correct	ction of bony vault only, if:
	(a) the indication for surgery is:	
	(i) airway obstruction and the p	batient has a self-reported NOSE Scale score of greater than 45; or
	(ii) significant acquired, congen	nital or developmental deformity; and
	(b) photographic and/or NOSE Scale documented in the patient notes (Ana	evidence demonstrating the clinical need for this service is aes.)
<b>Fee</b> 45635	(See para TN.8.104 of explanatory notes Fee: \$611.40 Benefit: 75% = Extended Medicare Safety Net Cap	\$458.55 85% = \$526.70
	Rhinoplasty, total, including correcti or without autogenous cartilage or be	on of all bony and cartilaginous elements of the external nose, with one graft from a local site (nasal), if:
	(a) the indication for surgery is:	
	(i) airway obstruction and the p	patient has a self-reported NOSE Scale score of greater than 45; or
	(ii) significant acquired, congen	nital or developmental deformity; and
	(b) photographic and/or NOSE Scale documented in the patient notes (Ana	evidence demonstrating the clinical need for this service is nes.)
<b>Fee</b> 45641	(See para TN.8.104 of explanatory notes <b>Fee:</b> \$1,109.20 <b>Benefit:</b> 75% =	
		on of all bony and cartilaginous elements of the external nose ge graft obtained from distant donor site, including obtaining of
	(a) the indication for surgery is:	
	(i) airway obstruction and the p	patient has a self-reported NOSE Scale score of greater than 45; or
	(ii) significant acquired, congen	nital or developmental deformity; and
	(b) photographic and/or NOSE Scale documented in the patient notes (Ana	evidence demonstrating the clinical need for this service is aes.) (Assist.)
Fee 45644	(See para TN.8.104 of explanatory notes	to this Category)

SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
Fee: \$1,331.25	<b>Benefit:</b> 75% = \$998.45		
CHOANAL ATR	ESIA, repair of by puncture and c	lilatation (Anaes.)	
Fee: \$232.70	<b>Benefit:</b> 75% = \$174.55		
CHOANAL ATR	ESIA - correction by open operat	ion with bone removal (Anaes.) (Assist.)	
Fee: \$936.90	<b>Benefit:</b> 75% = \$702.70 85%	= \$852.20	
		enous bone or cartilage graft (not being a service to	
(See para TN.8.105 <b>Fee:</b> \$1,331.25	of explanatory notes to this Category Benefit: 75% = \$998.45	)	
Rhinoplasty, revis	ion of, if:		
(a) the indication	for surgery is:		
(i) airway ob	struction and the patient has a se	f-reported NOSE Scale score of greater than 45; or	
(ii) significa	nt acquired, congenital or develop	omental deformity; and	
(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)			
(See para TN.8.104 <b>Fee:</b> \$153.75			
Rhinophyma of a (Anaes.)	moderate or severe degree, carbo	n dioxide laser or erbium laser excision - ablation of	
Fee: \$370.80         Benefit: 75% = \$278.10         85% = \$315.20           Extended Medicare Safety Net Cap: \$296.65			
RHINOPHYMA,	shaving of (Anaes.)		
Fee: \$370.80	<b>Benefit:</b> 75% = \$278.10 85%	= \$315.20	
COMPOSITE GR	AFT (Chondrocutaneous or chon	dromucosal) to nose, ear or eyelid (Anaes.) (Assist.)	
Fee: \$522.60	<b>Benefit:</b> 75% = \$391.95 85%	= \$444.25	
(a) the congenital 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) photographic evidence demonstrating the clinical need for this service is documented in the patient notes. (Anaes.) (Assist.)			
Fee: \$542.40	<b>Benefit:</b> 75% = \$406.80		
(b) the deformity	s characterised by an absence of	the antihelical fold and/or large scapha and/or large	
	Fee: \$1,331.25CHOANAL ATRIFee: \$232.70CHOANAL ATRIFee: \$936.90FACE, contour restwhich item 45644(See para TN.8.105Fee: \$1,331.25Rhinoplasty, revist(a) the indication f(i) airway ob(ii) significant(b) photographic atdocumented in the(See para TN.8.104Fee: \$153.75Rhinophyma of a tr(Anaes.)Fee: \$370.80Extended MedicatRHINOPHYMA, Fee: \$370.80COMPOSITE GRFee: \$522.60Correction of a cont(a) the congenitat(b) the deformitydeformity; and(c) photographic(a) the patient is let(a) the patient is let	Fee: \$1,331.25Benefit: 75% = \$998.45CHOANAL ATRESIA, repair of by puncture and defect \$232.70Benefit: 75% = \$174.55CHOANAL ATRESIA - correction by open operation of the system of the system operation operation of the system operation of the system operation of the system operation of the system operation operatis and system op	

T8. SUR	GICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	concha; and	
	(c) photographic e notes (Anaes.) (A	evidence demonstrating the clinical need for this service is documented in the patient ssist.)
	Fee: \$542.40	<b>Benefit:</b> 75% = \$406.80
Fee	grafts to form a fr congenital absenc	R, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage ramework, including the harvesting and sculpturing of the cartilage and its insertion, for e, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - pecialist in the practice of his or her specialty (Anaes.) (Assist.)
45660	Fee: \$2,995.35	<b>Benefit:</b> 75% = \$2246.55
Fee	framework using flaps and full thick	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.)
45661	Fee: \$1,331.25	<b>Benefit:</b> 75% = \$998.45
	CONGENITAL A	ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.)
<b>Fee</b> 45662	Fee: \$729.70	<b>Benefit:</b> 75% = \$547.30
	LIP, EYELID OR (Anaes.)	R EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures
Fee 45665	Fee: \$339.25	<b>Benefit:</b> 75% = \$254.45 85% = \$288.40
<b>D</b>	VERMILIONECT	TOMY, by surgical excision (Anaes.)
<b>Fee</b> 45668	Fee: \$339.25	<b>Benefit:</b> 75% = \$254.45 85% = \$288.40
	Vermilionectomy excision - ablation	for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser n (Anaes.)
<b>Fee</b> 45669	(See para TN.8.106 <b>Fee:</b> \$339.25	of explanatory notes to this Category) Benefit: 75% = \$254.45 85% = \$288.40
Б	LIP OR EYELID (Assist.)	RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.)
<b>Fee</b> 45671	Fee: \$867.85	<b>Benefit:</b> 75% = \$650.90 85% = \$783.15
Fee	LIP OR EYELID (Anaes.)	RECONSTRUCTION using full thickness flap (Abbe or similar), second stage
45674	Fee: \$252.40	<b>Benefit:</b> 75% = \$189.30 85% = \$214.55
	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.)	
<b>Fee</b> 45675	Fee: \$502.85	<b>Benefit:</b> 75% = \$377.15
	MACROSTOMIA	A, operation for (Anaes.) (Assist.)
<b>Fee</b> 45676	Fee: \$598.60	<b>Benefit:</b> 75% = \$448.95
	CLEFT LIP, unila	ateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)
Fee	1	

T8. SUR		DNS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	CLEFT LIP, unila	teral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)
<b>Fee</b> 45680	Fee: \$704.25	<b>Benefit:</b> 75% = \$528.20
	CLEFT LIP, bilate	eral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)
Fee 45683	Fee: \$782.35	<b>Benefit:</b> 75% = \$586.80
	CLEFT LIP, bilate	eral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)
<b>Fee</b> 45686	Fee: \$923.50	<b>Benefit:</b> 75% = \$692.65
	CLEFT LIP, lip ad	lhesion procedure, unilateral or bilateral (Anaes.) (Assist.)
<b>Fee</b> 45689	Fee: \$272.40	<b>Benefit:</b> 75% = \$204.30
Fac		al revision, including minor flap revision alignment and adjustment, including revision eformity if performed (Anaes.)
<b>Fee</b> 45692	Fee: \$312.95	<b>Benefit:</b> 75% = \$234.75 85% = \$266.05
T	CLEFT LIP, total whistle deformity	revision, including major flap revision, muscle reconstruction and revision of major (Anaes.) (Assist.)
<b>Fee</b> 45695	Fee: \$508.55	<b>Benefit:</b> 75% = \$381.45
	CLEFT LIP, prima	ary columella lengthening procedure, bilateral (Anaes.)
<b>Fee</b> 45698	Fee: \$477.35	<b>Benefit:</b> 75% = \$358.05
	CLEFT LIP RECO (Assist.)	DNSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.)
<b>Fee</b> 45701	Fee: \$860.85	<b>Benefit:</b> 75% = \$645.65
	CLEFT LIP RECO	ONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.)
<b>Fee</b> 45704	Fee: \$312.95	<b>Benefit:</b> 75% = \$234.75 85% = \$266.05
	CLEFT PALATE,	primary repair (Anaes.) (Assist.)
<b>Fee</b> 45707	Fee: \$813.60	<b>Benefit:</b> 75% = \$610.20
	CLEFT PALATE,	secondary repair, closure of fistula using local flaps (Anaes.)
<b>Fee</b> 45710	Fee: \$508.55	<b>Benefit:</b> 75% = \$381.45
	CLEFT PALATE,	secondary repair, lengthening procedure (Anaes.) (Assist.)
Fee 45713	Fee: \$579.15	<b>Benefit:</b> 75% = \$434.40
	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.)	
<b>Fee</b> 45714	Fee: \$813.60	<b>Benefit:</b> 75% = \$610.20
		GEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.)
<b>Fee</b> 45716	Fee: \$813.60	<b>Benefit:</b> 75% = \$610.20
	MANDIBLE OR 1	MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves one grafts taken from the same site and excluding services to which item 47933or
<b>Fee</b> 45720	(See para TN.8.107	of explanatory notes to this Category)

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	<b>Fee:</b> \$1,005.95 <b>Benefit:</b> 75% = \$7	54.50 85% = \$921.25
	and vessels and bone grafts taken from	Il osteotomy or osteectomy of, including transposition of nerves the same site and stabilisation with fixation by wires, screws, excluding services to which item 47933 or 47936 apply (Anaes.)
<b>Fee</b> 45723	(See para TN.8.107 of explanatory notes to <b>Fee:</b> \$1,134.50 <b>Benefit:</b> 75% = \$8	
		osteotomy or osteectomy of, including transposition of nerves the same site, and excluding services to which item 47933 or
<b>Fee</b> 45726	(See para TN.8.107 of explanatory notes to <b>Fee:</b> \$1,282.00 <b>Benefit:</b> 75% = \$9	
	and vessels and bone grafts taken from	osteotomy or osteectomy of, including transposition of nerves the same site and stabilisation with fixation by wires, screws, excluding services to which item 47933 or 47936 apply (Anaes.)
<b>Fee</b> 45729	(See para TN.8.107 of explanatory notes to <b>Fee:</b> \$1,439.75 <b>Benefit:</b> 75% = \$1	
		es or osteectomies of, involving 3 or more such procedures on the s and vessels and bone grafts taken from the same site, and 3 or 47936 apply (Anaes.) (Assist.)
<b>Fee</b> 45731	(See para TN.8.107 of explanatory notes to <b>Fee:</b> \$1,459.55 <b>Benefit:</b> 75% = \$1	
	the 1 jaw, including transposition of ne	nies or osteectomies of, involving 3 or more such procedures on rves and vessels and bone grafts taken from the same site and ews, plates or pins, or any combination, and excluding services to tes.) (Assist.)
<b>Fee</b> 45732	(See para TN.8.107 of explanatory notes to this Category) <b>Fee:</b> \$1,643.15 <b>Benefit:</b> 75% = \$1232.40	
		omies or osteectomies of, involving 2 such procedures of each and vessels and bone grafts taken from the same site, and 3 or 47936 apply (Anaes.) (Assist.)
<b>Fee</b> 45735	(See para TN.8.107 of explanatory notes to <b>Fee:</b> \$1,676.35 <b>Benefit:</b> 75% = \$1	
	jaw, including transposition of nerves a	omies or osteectomies of, involving 2 such procedures of each and vessels and bone grafts taken from the same site and ews, plates or pins, or any combination, and excluding services to as.) (Assist.)
Fee         (See para TN.8.107 of explanatory notes to this Category)           45738         Fee: \$1,885.80         Benefit: 75% = \$1414.35		
	such procedures of 1 jaw and 2 such pr	ex bilateral osteotomies or osteectomies of, involving 3 or more ocedures of the other jaw, including genioplasty when performed and bone grafts taken from the same site, and excluding services maes.) (Assist.)
<b>Fee</b> 45741	(See para TN.8.107 of explanatory notes to	this Category)

T8. SUR	GICAL OPERATIO	NS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$1,844.10	<b>Benefit:</b> 75% = \$1383.10	
	such procedures of and transposition of fixation by wires, so	MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed 5 nerves and vessels and bone grafts taken from the same site and stabilisation with crews, plates or pins, or any combination, and excluding services to which item bly (Anaes.) (Assist.)	
<b>Fee</b> 45744	(See para TN.8.107 of <b>Fee:</b> \$2,073.45	f explanatory notes to this Category) Benefit: 75% = \$1555.10	
	such procedures of	MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more each jaw, including genioplasty (when performed) and transposition of nerves and afts taken from the same site, and excluding services to which item 47933 or 47936 ist.)	
<b>Fee</b> 45747	(See para TN.8.107 of <b>Fee:</b> \$2,011.90	f explanatory notes to this Category) Benefit: 75% = \$1508.95 85% = \$1927.20	
	such procedures of vessels and bone grade	MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more each jaw, including genioplasty when performed and transposition of nerves and afts taken from the same site and stabilisation with fixation by wires, screws, plates bination, and excluding services to which item 47933 or 47936 apply (Anaes.)	
<b>Fee</b> 45752	(See para TN.8.107 of <b>Fee:</b> \$2,253.50	f explanatory notes to this Category) Benefit: 75% = \$1690.15	
Fee	III(Malar-Maxillary	EOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort ), Le Fort III involving 3 or more osteotomies of the midface including transposition ls and bone grafts taken from the same site (Anaes.) (Assist.)	
45753	Fee: \$2,266.85	<b>Benefit:</b> 75% = \$1700.15 85% = \$2182.15	
_	(Malar-Maxillary), nerves and vessels a	EOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III Le Fort III involving 3 or more osteotomies of the midface including transposition of and bone grafts taken from the same site and stabilisation with fixation by wires, hs, or any combination (Anaes.) (Assist.)	
<b>Fee</b> 45754	Fee: \$2,717.45	<b>Benefit:</b> 75% = \$2038.10	
Fee		IBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.)	
45755	<b>Fee:</b> \$382.65	<b>Benefit:</b> 75% = \$287.00 85% = \$325.30	
Fee	TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.)		
45758	Fee: \$684.75GENIOPLASTY, in (Anaes.) (Assist.)	<b>Benefit:</b> 75% = \$513.60 ncluding transposition of nerves and vessels and bone grafts taken from the same site	
<b>Fee</b> 45761	(See para TN.8.108 of <b>Fee:</b> \$779.00	f explanatory notes to this Category) Benefit: 75% = \$584.25	
<b>Fee</b> 45767	HYPERTELORISM	<b>A</b> , correction of, intracranial (Anaes.) (Assist.) <b>Benefit:</b> 75% = \$1960.10       85% = \$2528.75	
13707		$\frac{1}{1}$ , correction of, subcranial (Anaes.) (Assist.)	
<b>Fee</b> 45770	Fee: \$2,001.85	Benefit: 75% = \$1501.40	

T8. SUF	RGICAL OPERATI	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
_	TREACHER CO grafts (Anaes.) (A	LLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone Assist.)	
<b>Fee</b> 45773	Fee: \$1,824.40	<b>Benefit:</b> 75% = \$1368.30 85% = \$1739.70	
	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit,		
-	intracranial (Anac	es.) (Assist.)	
<b>Fee</b> 45776	Fee: \$1,824.40	<b>Benefit:</b> 75% = \$1368.30	
		COPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit,	
Fee	extracranial (Ana	es.) (Assist.)	
<b>гее</b> 45779	Fee: \$1,341.40	<b>Benefit:</b> 75% = \$1006.05	
	FRONTOORBIT	AL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.)	
Fee 45782	Fee: \$1,025.60	<b>Benefit:</b> 75% = \$769.20 85% = \$940.90	
		LT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar	
		ral frontoorbital advancement) (Anaes.) (Assist.)	
<b>Fee</b> 45785	Fee: \$1,735.70	<b>Benefit:</b> 75% = \$1301.80	
		A, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, hique) (Anaes.) (Assist.)	
<b>Fee</b> 45788	Fee: \$1,715.95	<b>Benefit:</b> 75% = \$1287.00	
		YLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, vesting of graft material (Anaes.) (Assist.)	
<b>Fee</b> 45791	Fee: \$926.95	<b>Benefit:</b> 75% = \$695.25	
	OSSEO-INTEGR	ATION PROCEDURE - extra-oral, implantation of titanium fixture, not for conduction hearing system device (Anaes.)	
<b>Fee</b> 45794	<b>Fee:</b> \$524.30	<b>Benefit:</b> 75% = \$393.25 85% = \$445.70	
		ATION PROCEDURE, fixation of transcutaneous abutment, not for implantable bone ng system device (Anaes.)	
<b>Fee</b> 45797	<b>Fee:</b> \$194.10 <b>Benefit:</b> 75% = \$145.60 85% = \$165.00		
-5777	<b>I CC.</b> \$194.10	ORAL AND MAXILLOFACIAL SURGERY	
	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to diagnostic purposes and not being a service associated with an operative procedure of (Anaes.)		
<b>Fee</b> 45799	Fee: \$30.60	<b>Benefit:</b> 75% = \$22.95 85% = \$26.05	
operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal fr		ue or from mucous membrane, where the removal is by surgical excision and suture,	
<b>Fee</b> 45801	(See para TN.8.109 <b>Fee:</b> \$132.10	of explanatory notes to this Category) Benefit: 75% = \$99.10 85% = \$112.30	
<b>Fee</b> 45803	an operation), in	STS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or ue or from mucous membrane, where the removal is by surgical excision and suture,	

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	and the procedure is performed on	more than 3 but not more than 10 lesions (Anaes.) (Assist.)	
	(See para TN.8.109 of explanatory note Fee: \$339.25 Benefit: 75%	es to this Category) = \$254.45	
	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.)		
<b>Fee</b> 45805	(See para TN.8.109 of explanatory note Fee: \$179.50 Benefit: 75%	es to this Category) = \$134.65	
	established by radiological examina lining and tooth structure or where ULCER OR SCAR (other than a sc	st associated with a tooth or tooth fragment unless it has been ation that there is a minimum of 5mm separation between the cyst a tumour or cyst has been proven by positive histopathology), ar removed during the surgical approach at an operation), in the oral of, not being a service to which another item in this Subgroup applies, sep tissue (Anaes.)	
<b>Fee</b> 45807	(See para TN.8.109 of explanatory note Fee: \$256.50 Benefit: 75%	es to this Category) = \$192.40	
	been established by radiological ex cyst lining and tooth structure or w	than a cyst associated with a tooth or tooth fragment unless it has amination that there is a minimum of 5mm separation between the here a tumour or cyst has been proven by positive histopathology), in emoval of, requiring wide excision, not being a service to which es (Anaes.) (Assist.)	
<b>Fee</b> 45809	(See para TN.8.109 of explanatory note Fee: \$386.55 Benefit: 75%	es to this Category) = \$289.95 85% = \$328.60	
		facial region, removal of, from soft tissue (including muscle, fascia accision of, without skin or mucosal graft (Anaes.) (Assist.)	
<b>Fee</b> 45811	(See para TN.8.109 of explanatory note Fee: \$522.60 Benefit: 75%	es to this Category) = \$391.95 85% = \$444.25	
	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.)		
<b>Fee</b> 45813	(See para TN.8.109 of explanatory note Fee: \$611.40 Benefit: 75%	es to this Category) = \$458.55 85% = \$526.70	
_	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.)		
<b>Fee</b> 45815	Fee: \$370.80 Benefit: 75%	= \$278.10 85% = \$315.20	
Ess	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.)		
<b>Fee</b> 45817	Fee: \$483.35 Benefit: 75%	= \$362.55 85% = \$410.85	
-		ATION OF ADJOINING BONES IN THE ORAL AND ng bones referred to in item 45817 (Anaes.) (Assist.)	
Fee 45819	Fee: \$611.35 Benefit: 75%	= \$458.55 85% = \$526.65	
	BONE GROWTH STIMULATOR (Anaes.) (Assist.)	IN THE ORAL AND MAXILLOFACIAL REGION, insertion of	
Fee	<b>Fee:</b> \$396.25 <b>Benefit:</b> 75%		

T8. SURGICAL OPERATIONS		IONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY		
<b>F</b>		or more, which were inserted for dental fixation purposes to the maxilla or mandible, iring general anaesthesia where undertaken in the operating theatre of a hospital		
Fee 45823	Fee: \$113.30	<b>Benefit:</b> 75% = \$85.00		
	MANDIBULAR	OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.)		
Fee 45825	Fee: \$352.05	<b>Benefit:</b> 75% = \$264.05 85% = \$299.25		
	MYLOHYOID F	RIDGE, reduction of (Anaes.) (Assist.)		
<b>Fee</b> 45827	Fee: \$336.50	<b>Benefit:</b> 75% = \$252.40 85% = \$286.05		
15027		'UBEROSITY, reduction of (Anaes.)		
Fee	Fee: \$256.70			
45829		<b>Benefit:</b> 75% = \$192.55 85% = \$218.20 YPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.)		
Fee				
45831	<b>Fee:</b> \$336.50	<b>Benefit:</b> 75% = \$252.40 85% = \$286.05		
Fee	PAPILLARY H	YPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.)		
45833	Fee: \$422.50	<b>Benefit:</b> 75% = \$316.90 85% = \$359.15		
-	PAPILLARY H	YPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.)		
<b>Fee</b> 45835	Fee: \$524.30	<b>Benefit:</b> 75% = \$393.25 85% = \$445.70		
-		ASTY, submucosal or open, including excision of muscle and skin or mucosal graft - unilateral or bilateral (Anaes.) (Assist.)		
<b>Fee</b> 45837	Fee: \$610.30	<b>Benefit:</b> 75% = \$457.75 85% = \$525.60		
		UTH LOWERING (Obwegeser or similar procedure), including excision of muscle and graft when performed - unilateral (Anaes.) (Assist.)		
Fee 45839	Fee: \$610.30	<b>Benefit:</b> 75% = \$457.75 85% = \$525.60		
	ALVEOLAR RI	DGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.)		
<b>Fee</b> 45841	<b>Fee:</b> \$492.85	<b>Benefit:</b> 75% = \$369.65 85% = \$418.95		
45041		DGE AUGMENTATION - unilateral, insertion of tissue expanding device into		
		adibular alveolar ridge region for (Anaes.) (Assist.)		
<b>Fee</b> 45843	Fee: \$302.30	<b>Benefit:</b> 75% = \$226.75 85% = \$257.00		
	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.)			
<b>Fee</b> 45845	Fee: \$524.30	<b>Benefit:</b> 75% = \$393.25 85% = \$445.70		
	RATION PROCEDURE - fixation of transmucosal abutment to fixtures placed on of part of the maxilla or mandible for benign or malignant tumours (Anaes.)			
<b>Fee</b> 45847	Fee: \$194.10	<b>Benefit:</b> 75% = \$145.60 85% = \$165.00		
13047		INUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining		
	(sinus lift procedure), (unilateral) (Anaes.) (Assist.)			
<b>Fee</b> 45849	Fee: \$604.45	<b>Benefit:</b> 75% = \$453.35 85% = \$519.75		
10017	400 1.15			

T8. SUR		DNS         13. PLASTIC AND RECONSTRUCTIVE SURGERY	
		DIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital, e associated with a service to which another item in this Subgroup applies (Anaes.)	
Fee 45851	<b>Fee:</b> \$148.80 <b>Benefit:</b> 75% = \$111.60		
	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not		
-	including harvesting	ng of graft material (Anaes.) (Assist.)	
Fee 45853	Fee: \$926.95	<b>Benefit:</b> 75% = \$695.25 85% = \$842.25	
		DIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service	
Fee	associated with an	y other arthroscopic procedure of that joint (Anaes.) (Assist.)	
45855	Fee: \$425.30	<b>Benefit:</b> 75% = \$319.00 85% = \$361.55	
_	of adhesions - 1 or	DIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment removes more such procedure of that joint, not being a service associated with any other edure of the temporomandibular joint (Anaes.) (Assist.)	
Fee 45857	Fee: \$680.25	<b>Benefit:</b> 75% = \$510.20 85% = \$595.55	
	TEMPOROMANI Subgroup applies	DIBULAR JOINT, arthrotomy of, not being a service to which another item in this (Anaes.) (Assist.)	
Fee 45859	Fee: \$342.90	<b>Benefit:</b> 75% = \$257.20 85% = \$291.50	
	TEMPOROMANI techniques (Anaes	DIBULAR JOINT, open surgical exploration of, with or without microsurgical .) (Assist.)	
Fee 45861	Fee: \$907.65	<b>Benefit:</b> 75% = \$680.75 85% = \$822.95	
<b>F</b>		DIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, icrosurgical techniques (Anaes.) (Assist.)	
Fee 45863	Fee: \$1,006.15	<b>Benefit:</b> 75% = \$754.65 85% = \$921.45	
_		SIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the pace(s) (Anaes.) (Assist.)	
Fee 45865	Fee: \$302.30	<b>Benefit:</b> 75% = \$226.75 85% = \$257.00	
	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)		
Fee 45867	Fee: \$324.95	<b>Benefit:</b> 75% = \$243.75 85% = \$276.25	
	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.)		
Fee 45869	Fee: \$1,236.35	<b>Benefit:</b> 75% = \$927.30 85% = \$1151.65	
		DIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar or without microsurgical techniques (Anaes.) (Assist.)	
Fee 45871	Fee: \$1,392.65	<b>Benefit:</b> 75% = \$1044.50 85% = \$1307.95	
	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants with or without microsurgical techniques (Anaes.) (Assist.)		
Fee			

T8. SUR	GICAL OPERAT	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
Fee		DIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of nal fixation, not being a service to which another item in this Subgroup applies (Anaes.)	
Fee 45875	Fee: \$489.75	<b>Benefit:</b> 75% = \$367.35 85% = \$416.30	
		DIBULAR JOINT, arthrodesis of, with synovectomy if performed, not being a service item in this Subgroup applies (Anaes.) (Assist.)	
<b>Fee</b> 45877	Fee: \$489.75	<b>Benefit:</b> 75% = \$367.35 85% = \$416.30	
F		DIBULAR JOINT OR JOINTS, application of external fixator to, other than for ures (Anaes.) (Assist.)	
Fee 45879	Fee: \$324.95	<b>Benefit:</b> 75% = \$243.75 85% = \$276.25	
-	The treatment of or carbon dioxide	a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy e laser.	
Fee 45882	Fee: \$44.75	<b>Benefit:</b> 75% = \$33.60 85% = \$38.05	
		ar or lingual artery or vein or artery and vein, ligation of, not being a service to which es (Anaes.) (Assist.)	
<b>Fee</b> 45885	Fee: \$461.65	<b>Benefit:</b> 75% = \$346.25 85% = \$392.45	
-	FOREIGN BOD techniques (Anae	Y, in the oral and maxillofacial region, deep, removal of using interventional imaging es.) (Assist.)	
Fee 45888	Fee: \$430.30	<b>Benefit:</b> 75% = \$322.75 85% = \$365.80	
T.	SINGLE-STAGE (Assist.)	E LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.)	
Fee 45891	Fee: \$626.90	<b>Benefit:</b> 75% = \$470.20 85% = \$542.20	
_	FREE GRAFTIN (Anaes.)	G, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area	
Fee 45894	Fee: \$213.00	<b>Benefit:</b> 75% = \$159.75 85% = \$181.05	
	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro- nasal fistulae and ridge augmentation (Anaes.) (Assist.)		
<b>Fee</b> 45897	Fee: \$1,112.40	<b>Benefit:</b> 75% = \$834.30 85% = \$1027.70	
	MANDIBLE, fix	ation by intermaxillary wiring, excluding wiring for obesity	
Fee 45900	Fee: \$250.90	<b>Benefit:</b> 75% = \$188.20 85% = \$213.30	
	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.)		
Fee 45939	Fee: \$465.20	<b>Benefit:</b> 75% = \$348.90 85% = \$395.45	
Fee	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.)		
гее 45945	Fee: \$123.50	<b>Benefit:</b> 75% = \$92.65 85% = \$105.00	
	MAXILLA, unil	ateral or bilateral, treatment of fracture of, not requiring splinting	
<b>Fee</b> 45975	(See para TN.8.110 <b>Fee:</b> \$134.40	) of explanatory notes to this Category) Benefit: 75% = \$100.80 85% = \$114.25	

T8. SUR	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	MANDIBLE, treatment of fracture of, not requiring splinting		
<b>Fee</b> 45978	(See para TN.8.110 of explanatory notes to this Category) <b>Fee:</b> \$164.25 <b>Benefit:</b> 75% = \$123.20 85% = \$139.65		
	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction		
<b>Fee</b> 45981	(See para TN.8.110 of explanatory notes to this Category) <b>Fee:</b> \$89.10 <b>Benefit:</b> 75% = \$66.85 85% = \$75.75		
	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Anaes.) (Assist.)		
<b>Fee</b> 45984	(See para TN.8.110 of explanatory notes to this Category)         Fee: \$641.60       Benefit: 75% = \$481.20       85% = \$556.90		
	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.)		
<b>Fee</b> 45987	(See para TN.8.110 of explanatory notes to this Category) <b>Fee:</b> \$641.60 <b>Benefit:</b> 75% = \$481.20 85% = \$556.90		
	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction involving the use of plate(s) (Anaes.) (Assist.)		
<b>Fee</b> 45990	(See para TN.8.110 of explanatory notes to this Category)         Fee: \$876.40       Benefit: 75% = \$657.30       85% = \$791.70		
	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.)		
<b>Fee</b> 45993	(See para TN.8.110 of explanatory notes to this Category) <b>Fee:</b> \$876.40 <b>Benefit:</b> 75% = \$657.30 85% = \$791.70		
	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.)		
<b>Fee</b> 45996	(See para TN.8.110 of explanatory notes to this Category)           Fee: \$248.45         Benefit: 75% = \$186.35         85% = \$211.20		
T8. SUR	GICAL OPERATIONS 14. HAND SURGERY		
	Group T8. Surgical Operations		
	Subgroup 14. Hand Surgery		
	Arthrodesis of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed):		
	(a) joint debridement;		
	(b) synovectomy		
Amend Fee	—one joint (H) (Anaes.) (Assist.)		
46300	Fee: \$422.55         Benefit: 75% = \$316.95		
Amond	Arthrodesis of carpometacarpal joint of hand, including either or both of the following (if performed):		
<b>Amend</b> <b>Fee</b> 46303	(a) joint debridement;		

T8. SUR	GICAL OPERATIONS 14. HAND SURGER		
	(b) synovectomy		
	one joint (H) (Anaes.) (Assist.)		
	<b>Fee:</b> \$547.85 <b>Benefit:</b> 75% = \$410.90		
	Volar plate or soft tissue interposition arthroplasty of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed):		
	(a) realignment procedures;		
	(b) tendon transfer		
	—one joint (Anaes.) (Assist.)		
<b>New</b> 46308	<b>Fee:</b> \$547.80 <b>Benefit:</b> 75% = \$410.85 85% = \$465.65		
	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed):		
	(a) ligament reconstruction;		
	(b) ligament realignment;		
	(c) synovectomy;		
	(d) tendon transfer		
Amend	—one joint (H) (Anaes.) (Assist.)		
<b>Fee</b> 46309	<b>Fee:</b> \$547.80 <b>Benefit:</b> 75% = \$410.85		
10507	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint		
	of hand, including any of the following (if performed):		
	(a) ligament reconstruction;		
	(b) ligament realignment;		
	(c) synovectomy;		
	(d) tendon transfer		
Amend	-2 joints of one hand (H) (Anaes.) (Assist.)		
<b>Fee</b> 46312	<b>Fee:</b> \$704.40 <b>Benefit:</b> 75% = \$528.30		
	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed):		
	(a) ligament reconstruction;		
	(b) ligament realignment;		
	(c) synovectomy;		
<b>Amend</b> <b>Fee</b> 46315	(d) tendon transfer		

T8. SUR	GICAL OPERATIONS 14. HAND SURGERY
	-3 joints of one hand (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$939.15 <b>Benefit:</b> 75% = \$704.40
	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed):
	(a) ligament reconstruction;
	(b) ligament realignment;
	(c) synovectomy;
	(d) tendon transfer
Amend Fee	-4 joints of one hand (H) (Anaes.) (Assist.)
46318	Fee: \$1,173.95         Benefit: 75% = \$880.50
	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed):
	(a) ligament reconstruction;
	(b) ligament realignment;
	(c) synovectomy;
	(d) tendon transfer;
Amend	-5 joints of one hand (H) (Anaes.) (Assist.)
Fee 46321	<b>Fee:</b> \$1,408.75 <b>Benefit:</b> 75% = \$1056.60
	Revision of prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpal joint of hand, including any of the following (if performed):
	(a) bone grafting;
	(b) ligament reconstruction;
	(c) ligament realignment;
	(d) synovectomy;
	(e) tendon or ligament reconstruction;
	(f) tendon transfer;
	—one joint (H) (Anaes.) (Assist.)
<b>New</b> 46322	<b>Fee:</b> \$821.80 <b>Benefit:</b> 75% = \$616.35
	Trapezium replacement arthroplasty or prosthetic interpositional replacement of carpometacarpal joint of thumb, including either or both of the following (if performed):
<b>Amend</b> <b>Fee</b> 46324	(a) ligament and tendon transfers;

T8. SUR	GICAL OPERATIONS 14. HAND SURGERY			
	(b) rebalancing procedures			
	(H) (Anaes.) (Assist.)			
	<b>Fee:</b> \$958.55 <b>Benefit:</b> 75% = \$718.95			
	Excisional arthroplasty of carpometacarpal joint of thumb, with excision of adjacent trapezoid, including either or both of the following (if performed):			
	(a) ligament and tendon transfers;			
	(b) realignment procedures			
Amend Fee	(H) (Anaes.) (Assist.)			
46325	<b>Fee:</b> \$958.55 <b>Benefit:</b> 75% = \$718.95			
	Ligamentous or capsular repair or reconstruction of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed):			
	(a) arthrotomy;			
	(b) joint stabilisation;			
	(c) synovectomy;			
Amend Fee	—one joint (H) (Anaes.) (Assist.)			
46330	Fee: \$360.10         Benefit: 75% = \$270.10			
	Ligamentous or capsular repair or reconstruction of interphalangeal or metacarpophalangeal joint of hand with graft, using graft or implant, including any of the following (if performed):			
	(a) arthrotomy;			
	(b) harvest of graft;			
	(c) joint stabilisation;			
	(d) synovectomy;			
Amend	other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 apply—one joint (H) (Anaes.) (Assist.)			
Fee 46333	<b>Fee:</b> \$586.90 <b>Benefit:</b> 75% = \$440.20			
	Synovectomy of digital extensor tendons of hand, distal to wrist, for diagnosed inflammatory arthritis, including any of the following (if performed):			
	(a) reconstruction of extensor retinaculum;			
	(b) removal of tendon nodules;			
	(c) tenolysis;			
	(d) tenoplasty;			
<b>New</b> 46335	other than a service associated with a service to which item 30023, 39331 or 39330 applies—applicable			

T8. SUR	GICAL OPERATIONS 14. HAND SURGER		
	only once per occasion on which the service is performed (Anaes.) (Assist.)		
	Fee: \$485.10         Benefit: 75% = \$363.85         85% = \$412.35		
	Synovectomy of interphalangeal, metacarpophalangeal or carpometacarpal joint of hand, including any of the following (if performed):		
	(a) capsulectomy;		
	(b) debridement;		
	(c) ligament or tendon realignment (or both);		
Amend Fee	other than a service combined with a service to which item 46495 applies—one joint (Anaes.) (Assist.)		
<b>Fee</b> 46336	Fee:         \$273.95         Benefit:         75% = \$205.50         85% = \$232.90		
	Synovectomy of digital flexor tendons at wrist level, for diagnosed inflammatory arthritis, including either or both of the following (if performed):		
	(a) tenolysis;		
	(b) release of median nerve and carpal tunnel;		
Amend	other than a service associated with a service to which item 30023, 39331 or 39330 applies—applicable only once per occasion on which the service is performed (H) (Anaes.) (Assist.)		
Fee 46339	<b>Fee:</b> \$485.10 <b>Benefit:</b> 75% = \$363.85		
	Synovectomy of wrist flexor or extensor tendons of hand or wrist, for diagnosed inflammatory tenosynovitis, including any of the following (if performed):		
	(a) reconstruction of flexor or extensor retinaculum;		
	(b) removal of tendon nodules;		
	(c) tenolysis;		
	(d) tenoplasty;		
	other than a service associated with a service to which item 30023, 39331 or 39330 applies—one or more compartments (H) (Anaes.) (Assist.)		
<b>New</b> 46340	<b>Fee:</b> \$412.35 <b>Benefit:</b> 75% = \$309.30		
	Synovectomy of wrist flexor or extensor tendons of hand or wrist, for non-inflammatory tenosynovitis of post traumatic synovitis, including any of the following (if performed):		
	(a) reconstruction of flexor or extensor retinaculum;		
	(b) removal of tendon nodules;		
	(c) tenolysis;		
	(d) tenoplasty;		
<b>New</b> 46341	other than a service associated with a service to which item 30023, 39331 or 39330 applies—one or more compartments (H) (Anaes.) (Assist.)		

T8. SUR	GICAL OPERAT	IONS	14. HAND SURGERY		
	Fee: \$264.45	<b>Benefit:</b> 75% = \$198.35			
Amend Fee	Synovectomy of (Assist.)	distal radioulnar or carpometacarpal	joint of hand—one or more joints (H) (Anaes.)		
46342	Fee: \$485.10	<b>Benefit:</b> 75% = \$363.85			
	Resection arthroplasty of distal radioulnar joint of hand, partial or complete, including any of the following (if performed):				
	(a) ligament or tendon reconstruction;				
	(b) joint stabilisation;				
	(c) synovectomy				
Amend Fee	(H) (Anaes.) (As	sist.)			
46345	Fee: \$586.90	<b>Benefit:</b> 75% = \$440.20			
	Flexor tenosynov performed):	rectomy of hand, distal to lumbrical	origin, including any of the following (if		
	(a) removal of in	tratendinous nodules;			
	(b) tenolysis;				
	(c) tenoplasty;				
Amend Fee	other than a servi (Anaes.) (Assist.)		n item 30023 or 46363 applies—one ray (H)		
46348	Fee: \$254.35	<b>Benefit:</b> 75% = \$190.80			
	Flexor tenosynov performed):	rectomy of hand, distal to lumbrical of	origin, including any of the following (if		
	(a) removal of intratendinous nodules;				
	(b) tenolysis;				
	(c) tenoplasty;				
Amend	other than a service associated with a service to which item 30023 or 46363 applies—2 rays of one han (H) (Anaes.) (Assist.)				
<b>Fee</b> 46351	Fee: \$379.60	<b>Benefit:</b> 75% = \$284.70			
	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed):				
	(a) removal of intratendinous nodules;				
	(b) tenolysis;				
	(c) tenoplasty;				
<b>Amend</b> <b>Fee</b> 46354	other than a servi (H) (Anaes.) (As		n item 30023 or 46363 applies—3 rays of one hand		

T8. SUR	GICAL OPERAT	IONS	14. HAND SURGERY	
	Fee: \$508.65	<b>Benefit:</b> 75% = \$381.50		
	Flexor tenosynov performed):	vectomy of hand, distal to lumbrical	origin, including any of the following (if	
	(a) removal of in	tratendinous nodules;		
	(b) tenolysis;			
	(c) tenoplasty;			
Amend Fee	other than a service associated with a service to which item 30023 or 46363 applies—4 rays of one hand (H) (Anaes.) (Assist.)			
46357	Fee: \$633.90	<b>Benefit:</b> 75% = \$475.45		
	Flexor tenosynov performed):	vectomy of hand, distal to lumbrical	origin, including any of the following (if	
	(a) removal of in	tratendinous nodules;		
	(b) tenolysis;			
	(c) tenoplasty;			
Amend Fee	other than a service associated with a service to which item 30023 or 46363 applies—5 rays of one hand (H) (Anaes.) (Assist.)			
46360	Fee: \$763.10	<b>Benefit:</b> 75% = \$572.35		
	Trigger finger release, for stenosing tenosynoviti, including either or both of the following (if performed):			
	(a) synovectomy	;		
	(b) synovial biopsy;			
Amend Fee	—one ray (Anae	s.) (Assist.)		
46363	Fee: \$219.10	<b>Benefit:</b> 75% = \$164.35 85% =	\$186.25	
	Digital sympathectomy of hand, using microsurgical techniques, other than a service associated with a service to which item 30023 or 46363 applies—one digit or palmer arch (or both) or radial or ulnar artery (or both) (Anaes.) (Assist.)			
New	artery (or both) (.	Allaes.) (Assist.)		
46364	Fee: \$485.10	<b>Benefit:</b> 75% = \$363.85 85% =	\$412.35	
<b>N</b> T	Excision of rheur	matoid nodules of handone lesio	n (Anaes.) (Assist.)	
<b>New</b> 46365	Fee: \$273.95	<b>Benefit:</b> 75% = \$205.50 85% =	\$232.90	
	De Quervain's release, including any of the following (if performed):			
	(a) synovectomy of extensor pollicis brevis;			
	(b) synovectomy of abductor pollicis longus tendons;			
<b>New</b> 46367	(c) retinaculum r	econstruction;		

T8. SUR	GICAL OPERATIO	NS	14. HAND SURGERY
	other than a service	associated with a service to which item 4633	39 applies (Anaes.) (Assist.)
	Fee: \$413.70	<b>Benefit:</b> 75% = \$310.30 85% = \$351.65	
	Percutaneous fascio both of the followin	tomy for Dupuytren's contracture, by needle g (if performed):	or chemical method, including either or
	(a) immediate or de	layed manipulation;	
	(b) local or regional	nerve block;	
New	—one ray (Anaes.)	(Assist.)	
46370	Fee: \$133.10	<b>Benefit:</b> 75% = \$99.85 85% = \$113.15	
Amend Fee	Fasciectomy for Du (Anaes.) (Assist.)	puytren's contracture, including dissection o	f nerves (if performed)—one ray (H)
46372	Fee: \$445.25	<b>Benefit:</b> 75% = \$333.95	
Amend	Fasciectomy for Du (Anaes.) (Assist.)	puytren's contracture, including dissection o	f nerves (if performed)—2 rays (H)
Fee 46375	Fee: \$528.25	<b>Benefit:</b> 75% = \$396.20	
Amend Fee	Fasciectomy for Du (Anaes.) (Assist.)	puytren's contracture, including dissection o	f nerves (if performed)—3 rays (H)
46378	Fee: \$704.40	<b>Benefit:</b> 75% = \$528.30	
	Fasciectomy for Du (Anaes.) (Assist.)	puytren's contracture, including dissection o	f nerves (if performed)—4 rays (H)
New 46379	Fee: \$887.40	<b>Benefit:</b> 75% = \$665.55	
New	Fasciectomy for Du (Anaes.) (Assist.)	puytren's contracture, including dissection o	f nerves (if performed)—5 rays (H)
46380	Fee: \$1,118.05	<b>Benefit:</b> 75% = \$838.55	
Amend		angeal joint of hand, by open procedure, whe tren's contracture—one joint (H) (Anaes.) (A	
Fee 46381	Fee: \$313.00	<b>Benefit:</b> 75% = \$234.75	
Amend	Z-plasty or similar local flap procedure, when performed in conjunction with an operation for Dupuytren's contracture, including raising, transfer in-setting and suturing of both components (flaps)— one Z-plasty or local flap procedure (H) (Anaes.) (Assist.)		
Fee	E \$212.00	Domoffett 750/ \$224.75	
46384	Fee: \$313.00 Fasciectomy for rec	<b>Benefit:</b> 75% = \$234.75 urrence of Dupuytren's contracture, includin	g either or both of the following (if
	performed):		
	(a) dissection of nerves;		
	(b) neurolysis;		
<b>Amend</b> <b>Fee</b> 46387	other than a service (Assist.)	associated with a service to which item 3002	23 applies—one ray (H) (Anaes.)

T8. SUR	GICAL OPERATI	DNS 14. HAND SURGE	RY
	Fee: \$645.75	<b>Benefit:</b> 75% = \$484.35	
	Fasciectomy for performed):	ecurrence of Dupuytren's contracture, including either or both of the following (if	
	(a) dissection of a	erves;	
	(b) neurolysis;		
Amend Fee	other than a servi	e associated with a service to which item 30023 applies-2 rays (H) (Anaes.) (Assist	st.)
46390	Fee: \$861.05	<b>Benefit:</b> 75% = \$645.80	
	Fasciectomy for performed):	ecurrence of Dupuytren's contracture, including either or both of the following (if	
	(a) dissection of a	erves;	
	(b) neurolysis;		
Amend Fee	other than a servi	e associated with a service to which item 30023 applies—3 rays (H) (Anaes.) (Assis	st.)
46393	Fee: \$997.85	<b>Benefit:</b> 75% = \$748.40	
	Fasciectomy for performed):	ecurrence of Dupuytren's contracture, including either or both of the following (if	
	(a) dissection of a	erves;	
	(b) neurolysis;		
N	other than a servi	e associated with a service to which item 30023 applies-4 rays (H) (Anaes.) (Assist	st.)
<b>New</b> 46394	Fee: \$1,243.45	<b>Benefit:</b> 75% = \$932.60	
	Fasciectomy for performed):	ecurrence of Dupuytren's contracture, including either or both of the following (if	
	(a) dissection of a	erves;	
	(b) neurolysis;		
New	other than a servi	re associated with a service to which item 30023 applies—5 rays (H) (Anaes.) (Assist	st.)
46395	Fee: \$1,549.55	<b>Benefit:</b> 75% = \$1162.20	
Amend	Osteotomy of pha	lanx or metacarpal of hand, with internal fixation—one bone (H) (Anaes.) (Assist.)	
Fee 46399	Fee: \$538.80	<b>Benefit:</b> 75% = \$404.10	
	Operative treatment of non-union of phalanx or metacarpal of hand, including internal fixat performed) (Anaes.) (Assist.)		
<b>New</b> 46401	Fee: \$432.45	<b>Benefit:</b> 75% = \$324.35 85% = \$367.60	
	Reconstruction o performed):	tendon of hand or wrist, by tendon graft, including either or both of the following (i	if
<b>Amend</b> <b>Fee</b> 46408	(a) harvest of gra	t;	

T8. SUR	GICAL OPERAT	IONS 14. HAND SURGERY
	(b) tenolysis;	
	other than a serv	ice associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)
	Fee: \$720.00	<b>Benefit:</b> 75% = \$540.00
Amend Fee	Reconstruction of complete flexor tendon pulley of hand or wrist, with graft, including harvest of graft (if performed)—one pulley (H) (Anaes.) (Assist.)	
46411	Fee: \$422.60	<b>Benefit:</b> 75% = \$316.95
Amend Fee		cial tendon prosthesis in preparation for grafting of tendon of hand or wrist, including prmed), other than a service associated with a service to which item 30023 applies )
46414	Fee: \$547.70	<b>Benefit:</b> 75% = \$410.80 85% = \$465.55
Amend Fee		on of hand or wrist, for restoration of hand or digit motion, including harvest of donor rformed)—one transfer (H) (Anaes.) (Assist.)
46417	Fee: \$508.65	<b>Benefit:</b> 75% = \$381.50
Amend	Primary repair of	f extensor tendon of hand or wrist-one tendon (Anaes.) (Assist.)
<b>Fee</b> 46420	Fee: \$212.85	<b>Benefit:</b> 75% = \$159.65 85% = \$180.95
Amend Fee	• •	f extensor tendon of hand or wrist, including tenolysis (if performed), other than a d with a service to which item 30023 applies (Anaes.) (Assist.)
46423	Fee: \$340.45	<b>Benefit:</b> 75% = \$255.35 85% = \$289.40
Amend Fee		f flexor tendon of hand or wrist, proximal to A1 pulley, other than a service to repair a if 2 tendons of the same digit have been repaired during the same procedure—one es.) (Assist.)
46426	Fee: \$352.10	<b>Benefit:</b> 75% = \$264.10
Amend Fee		f flexor tendon of hand or wrist, distal to A1 pulley, other than a service to repair a if 2 tendons of the same digit have been repaired during the same procedure—one es.) (Assist.)
46432	Fee: \$587.10	<b>Benefit:</b> 75% = \$440.35
New		f flexor tendon of hand or wrist, including tenolysis (if performed), other than a service a service to which item 30023 applies (Anaes.) (Assist.)
46434	Fee: \$505.80	<b>Benefit:</b> 75% = \$379.35 85% = \$429.95
Amend	Closed pin fixati	on of mallet finger (Anaes.)
<b>Fee</b> 46438	Fee: \$140.90	<b>Benefit:</b> 75% = \$105.70 85% = \$119.80
	Open reduction of	of mallet finger, including any of the following (if performed):
	(a) joint release;	
	(b) pin fixation;	
	(c) tenolysis	
<b>Amend</b> <b>Fee</b> 46441	(Anaes.) (Assis	t.)

T8. SUR	GICAL OPERATIC	INS	14. HAND SURGERY
	Fee: \$340.45	<b>Benefit:</b> 75% = \$255.35 85% = \$289.40	
-		R with intra articular fracture involving more than one t uction (Anaes.) (Assist.)	hird of base of terminal
<b>Fee</b> 46442	Fee: \$292.25	<b>Benefit:</b> 75% = \$219.20	
	Reconstruction of (if performed):	Boutonniere or swan neck deformity of hand, including	g either or both of the following
	(a) tendon graft ha	rvest;	
	(b) tendon transfer		
Amend Fee	—one joint (H) (A	naes.) (Assist.)	
46444	Fee: \$508.65	<b>Benefit:</b> 75% = \$381.50	
	Tenolysis of extent	sor tendon of hand or wrist, following tendon injury or	graft, other than a service:
	(a) for acute, traum	natic injury; or	
	(b) associated with	a service to which item 30023 applies	
Amend	—one ray (H) (An	aes.)	
<b>Fee</b> 46450	Fee: \$234.85	<b>Benefit:</b> 75% = \$176.15	
	Tenolysis of flexor	tendon of hand or wrist, following tendon injury, repa	ir or graft, other than a service:
	(a) for acute, traumatic injury; or		
	(b) associated with	a service to which item 30023 applies	
Amend	(H) (Anaes.) (Assi	st.)	
<b>Fee</b> 46453	Fee: \$391.35	<b>Benefit:</b> 75% = \$293.55	
Amend	Percutaneous tenot	romy of digit of hand (Anaes.)	
<b>Fee</b> 46456	Fee: \$101.75	<b>Benefit:</b> 75% = \$76.35 85% = \$86.50	
Amend Fee	Amputation of a su	pernumerary complete digit of hand (H) (Anaes.) (Ass	ist.)
46464	Fee: \$234.85	<b>Benefit:</b> 75% = \$176.15	
	Amputation of dig	t of hand, distal to metacarpal head, including any of th	ne following (if performed):
	(a) excision of neuroma;		
	(b) resection of bone;		
	(c) skin cover with local flaps		
Amend Fee	—one ray (H) (An	aes.) (Assist.)	
46465	Fee: \$234.85	<b>Benefit:</b> 75% = \$176.15	
	Amputation of dig	it of hand, distal to metacarpal head, including any of th	ne following (if performed):
<b>Amend</b> <b>Fee</b> 46468	(a) excision of neu	roma;	

T8. SUR	GICAL OPERAT	ONS 14. HAND SURGERY
	(b) resection of b	one;
	(c) skin cover wi	h local flaps
	—2 rays (H) (Ar	aes.) (Assist.)
	Fee: \$410.85	<b>Benefit:</b> 75% = \$308.15
	Amputation of d	git of hand, distal to metacarpal head, including any of the following (if performed):
	(a) excision of n	uroma;
	(b) resection of b	one;
	(c) skin cover wi	h local flaps
Amend	—3 rays (H) (Ar	aes.) (Assist.)
<b>Fee</b> 46471	Fee: \$586.90	<b>Benefit:</b> 75% = \$440.20
	Amputation of d	git of hand, distal to metacarpal head, including any of the following (if performed):
	(a) excision of n	uroma;
	(b) resection of b	one;
	(c) skin cover wi	h local flaps
Amend Fee	—4 rays (H) (Ai	aes.) (Assist.)
46474	Fee: \$763.10	<b>Benefit:</b> 75% = \$572.35
	Amputation of d	git of hand, distal to metacarpal head, including any of the following (if performed):
	(a) excision of n	uroma;
	(b) resection of b	one;
	(c) skin cover wi	h local flaps
Amend	—5 rays (H) (Ar	aes.) (Assist.)
<b>Fee</b> 46477	Fee: \$939.15	<b>Benefit:</b> 75% = \$704.40
	Amputation of ra	y of hand, proximal to metacarpal head, including any of the following (if performed):
	(a) excision of n	uroma;
	(b) recontouring	
	(c) resection of b	one;
	(d) skin cover w	h local flaps
Amend	—one ray (H) (A	naes.) (Assist.)
<b>Fee</b> 46480	Fee: \$391.35	<b>Benefit:</b> 75% = \$293.55
Amend Fee	Revision of amp	tation stump of hand to provide adequate cover, including any of the following (if

T8. SUR	GICAL OPERATIO	NS 14. HAND SURGERY	
46483	performed):		
	(a) bone shortening	;	
	(b) excision of nail	bed remnants;	
	(c) excision of neur	oma	
	(H) (Anaes.) (Assis	t.)	
	Fee: \$313.00	<b>Benefit:</b> 75% = \$234.75	
Amend Fee	Accurate reconstru	ction of nail bed laceration using magnification (H) (Anaes.)	
<b>ree</b> 46486	Fee: \$234.85	<b>Benefit:</b> 75% = \$176.15	
Amend Fee		uction of nail bed deformity using magnification, including removal of nail (if nan a service associated with a service to which item 46513 or 45451 applies (H)	
ree 46489	Fee: \$273.95	<b>Benefit:</b> 75% = \$205.50	
Amend Fee		of contracture of joint of hand, flexor or extensor tendon, involving tissues deeper taneous tissue—one joint (H) (Anaes.) (Assist.)	
46492	Fee: \$375.70	<b>Benefit:</b> 75% = \$281.80	
	<ul><li>(a) excision of gang</li><li>(b) synovectomy</li><li>(Anaes.) (Assist.)</li></ul>	f metacarpal base of hand, including either or both of the following (if performed): glion;	
<b>New</b> 46493	Fee: \$342.90	<b>Benefit:</b> 75% = \$257.20 85% = \$291.50	
		of one or more ganglia or mucous cysts of interphalangeal, metacarpophalangeal or int of hand, including any of the following (if performed):	
	(a) arthrotomy;		
	(b) osteophyte rese	ctions	
	(c) synovectomy		
Amend Fee	other than a service associated with a service to which item 30107 or 46336 applies—one joint ((Anaes.) (Assist.)		
46495	Fee: \$211.40	<b>Benefit:</b> 75% = \$158.55	
	Excision of ganglic	n of flexor tendon sheath of hand, including any of the following (if performed):	
	(a) flexor tenosynovectomy;		
	(b) sheath excision		
<b>Amend</b> <b>Fee</b> 46498	(c) skin closure by	any method	

T8. SUR	GICAL OPERATION	ONS	14. HAND SURGERY
	other than a service	ce associated with a service to which ite	em 30106, 30107 or 46363 applies (Anaes.)
	Fee: \$228.85	<b>Benefit:</b> 75% = \$171.65 85% = \$194	1.55
	Excision of gangl	ion of dorsal wrist joint of hand, includi	ing any of the following (if performed):
	(a) arthrotomy;		
	(b) capsular or lig	ament repair (or both);	
	(c) synovectomy		
Amend	other than a service	ce associated with a service to which ite	em 30106 or 30107 applies (Anaes.) (Assist.)
<b>Fee</b> 46500	Fee: \$273.95	<b>Benefit:</b> 75% = \$205.50 85% = \$232	2.90
	Excision of gangl	ion of volar wrist joint of hand, includir	ng any of the following (if performed):
	(a) arthrotomy;		
	(b) capsular or lig	ament repair (or both);	
	(c) synovectomy;		
Amend	other than a servic (Assist.)	ce associated with a service to which ite	em 30106, 30107 or 46325 applies (Anaes.)
<b>Fee</b> 46501	Fee: \$342.50	<b>Benefit:</b> 75% = \$256.90 85% = \$291	.15
	Excision of recurr performed):	rent ganglion of dorsal wrist joint of har	nd, including any of the following (if
	(a) arthrotomy;		
	(b) capsular or lig	ament repair (or both);	
	(c) synovectomy		
Amend	(Anaes.) (Assist.	)	
<b>Fee</b> 46502	Fee: \$410.90	<b>Benefit:</b> 75% = \$308.20 85% = \$349	0.30
	Excision of recurr		d, including any of the following (if performed):
	(a) arthrotomy;		
	(b) capsular or lig	ament repair (or both);	
	(c) synovectomy;		
Amend	other than a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)		
<b>Fee</b> 46503	Fee: \$393.70	<b>Benefit:</b> 75% = \$295.30 85% = \$334	
Amend			vation and soft tissue cover (Anaes.) (Assist.)
<b>Fee</b> 46504	Fee: \$1,150.35	<b>Benefit:</b> 75% = \$862.80 85% = \$106	55.65
Amend Fee		ransfer of digit or ray on vascular pedic	

T8. SUR	GICAL OPERATIO	DNS 14. HAND SURGERY	
	performed):		
	<ul><li>(a) nerve transfer;</li><li>(b) skin closure, by any means;</li></ul>		
	(c) rebalancing procedures		
	(H) (Anaes.) (Assi	st.)	
	Fee: \$1,560.75	<b>Benefit:</b> 75% = \$1170.60	
	Surgical reduction performed):	of enlarged elements resulting from macrodactyly, including any of the following (if	
	(a) nerve transfer;		
	(b) skin closure, b	/ any means;	
	(c) rebalancing pro	ocedures	
Amend Fee	—one digit (H) (A	naes.) (Assist.)	
46510	Fee: \$365.20	<b>Benefit:</b> 75% = \$273.90	
Amend	Removal of nail of	finger or thumb—one nail (Anaes.)	
<b>Fee</b> 46513	Fee: \$58.75	<b>Benefit:</b> 75% = \$44.10 85% = \$49.95	
Amend	Drainage of midpa (Assist.)	lmar, thenar or hypothenar spaces or dorsum of hand, excluding aftercare (Anaes.)	
<b>Fee</b> 46519	Fee: \$146.95	<b>Benefit:</b> 75% = \$110.25 85% = \$124.95	
	Open operation an both of the follow:	d drainage of infection for flexor tendon sheath of finger or thumb, including either or ng (if performed):	
	(a) synovectomy;		
	(b) tenolysis;		
Amend	other than a service associated with a service to which item 30023 applies—one digit (H) (Anaes.) (Assist.)		
<b>Fee</b> 46522	Fee: \$438.25	<b>Benefit:</b> 75% = \$328.70	
	Incision for pulp s	pace infection of hand:	
	(a) other than a set	vice:	
	(i) to which another item in this Group applies; or		
	(ii) associated with a service to which item 30023 applies; and		
	(b) excluding aftercare		
Amend	(H) (Anaes.)		
Fee 46525	Fee: \$58.75	<b>Benefit:</b> 75% = \$44.10	

T8. SUR	GICAL OPERAT	IONS	14. HAND SURGERY
	Wedge resection	for ingrowing nail of finger or thumb:	
	(a) including eac	h of the following:	
	(i) excision	and partial ablation of germinal matrix;	
	(ii) remova	l of segment of nail;	
	(iii) remova	al of ungual fold; and	
	(b) including phe	nolisation (if performed)	
Amend Fee	(Anaes.)		
46528	Fee: \$176.35	<b>Benefit:</b> 75% = \$132.30 85% = \$149.90	
Amend Fee	Partial resection	of ingrowing nail of finger or thumb, including phenolis	sation (Anaes.)
46531	Fee: \$88.60	<b>Benefit:</b> 75% = \$66.45 85% = \$75.35	
Amend	Complete ablation	n of nail germinal matrix (H) (Anaes.)	
<b>Fee</b> 46534	Fee: \$245.05	<b>Benefit:</b> 75% = \$183.80	
T8. SUR	GICAL OPERAT	ONS	15. ORTHOPAEDIC
	Group T8. Surgi	cal Operations	
	Subgroup 15. Orthopaedic		
	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed):		
	(a) capsulotomy;		
	(b) joint release;		
	(c) synovectomy;		
	(d) local tendon transfer;		
	(e) joint debrider	nent;	
	—3 joints (H) (A	naes.) (Assist.)	
<b>New</b> 49783	Fee: \$789.00	<b>Benefit:</b> 75% = \$591.75	
		TREATMENT OF DISLOCATIONS	
Amend	Treatment of dislocation of mandible, by closed reduction (Anaes.)		
<b>Fee</b> 47000	Fee: \$73.55	<b>Benefit:</b> 75% = \$55.20 85% = \$62.55	
Amend	Treatment of dis	ocation of clavicle, by closed reduction (Anaes.)	
<b>Fee</b> 47003	Fee: \$88.25	<b>Benefit:</b> 75% = \$66.20 85% = \$75.05	
<b>New</b> 47007		oclavicular or sternoclavicular joint dislocation (acute of echnique, including either or both of the following (if pe	

T8. SUR	GICAL OPERAT	ONS 15. ORTHOPAEDIC
	(a) ligament aug	nentation;
	(b) tendon transf	ers
	(Anaes.) (Assis	)
	Fee: \$367.35	<b>Benefit:</b> 75% = \$275.55 85% = \$312.25
Amend	Treatment of dislitem 47012 appli	ocation of shoulder, requiring general anaesthesia, other than a service to which es (Anaes.)
<b>Fee</b> 47009	Fee: \$176.35	<b>Benefit:</b> 75% = \$132.30 85% = \$149.90
Amend Fee	(Assist.)	ocation of shoulder, requiring general anaesthesia, by open reduction (H) (Anaes.)
47012	Fee: \$352.55	<b>Benefit:</b> 75% = \$264.45
Amend Fee		ocation of shoulder, not requiring general anaesthesia
47015	Fee: \$88.25	<b>Benefit:</b> 75% = \$66.20 85% = \$75.05
<b>Amend</b> <b>Fee</b> 47018	<b>Fee:</b> \$205.60	ocation of elbow, by closed reduction (Anaes.) Benefit: 75% = \$154.20 85% = \$174.80
Amend	Treatment of dis	ocation of elbow, by open reduction (H) (Anaes.) (Assist.)
<b>Fee</b> 47021	Fee: \$274.25	<b>Benefit:</b> 75% = \$205.70
Amend Fee	associated with a other item is for	ocation of distal or proximal radioulnar joint, by closed reduction, other than a service service to which another item in this Schedule applies if the service described in the he purpose of treating fracture or dislocation in the same region (Anaes.)
47024	Fee: \$205.60	<b>Benefit:</b> 75% = \$154.20 85% = \$174.80
		ocation of distal or proximal radioulnar joint, by open reduction, including either or ving (if performed):
	(a) styloid fractu	re;
	(b) triangular fib	ocartilage complex repair;
Amend	other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating fracture or dislocation in the same regio (Anaes.) (Assist.)	
<b>Fee</b> 47027	Fee: \$676.05	<b>Benefit:</b> 75% = \$507.05 85% = \$591.35
Amend	Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by closed reduction (Anaes.)	
<b>Fee</b> 47030	Fee: \$205.60	<b>Benefit:</b> 75% = \$154.20 85% = \$174.80
Amend Fee	Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by open reduction, including ligament repair (if performed) (Anaes.) (Assist.)	
47033	Fee: \$676.05	<b>Benefit:</b> 75% = \$507.05 85% = \$591.35
Amend Fee		ocation of interphalangeal or metacarpophalangeal joint, by closed reduction (Anaes.)
47042	Fee: \$117.40	<b>Benefit:</b> 75% = \$88.05 85% = \$99.80

T8. SUR	GICAL OPERAT	IONS	15. ORTHOPAEDIC
		location of interphalangeal or metacarpoph ving (if performed):	alangeal joint, by open reduction, including
	(a) arthrotomy;		
	(b) capsule repai	r;	
	(c) ligament repa	ir;	
	(d) volar plate re	pair	
Amend	(Anaes.) (Assis	- t.)	
Fee 47045	Fee: \$438.55	<b>Benefit:</b> 75% = \$328.95 85% = \$372.8	0
	Treatment of dis	location of prosthetic hip, by closed reduct	ion (Anaes.) (Assist.)
<b>New</b> 47047	Fee: \$337.95	<b>Benefit:</b> 75% = \$253.50 85% = \$287.3	0
	Treatment of dis	location of prosthetic hip, by open reduction	on (Anaes.) (Assist.)
New 47049	Fee: \$450.50	<b>Benefit:</b> 75% = \$337.90 85% = \$382.9	5
	Treatment of dis	location of native hip, by closed reduction	(Anaes.) (Assist.)
<b>New</b> 47052	Fee: \$439.35	<b>Benefit:</b> 75% = \$329.55 85% = \$373.4	5
			with internal fixation (if performed) (Anaes.)
<b>New</b> 47053	Fee: \$585.65	<b>Benefit:</b> 75% = \$439.25 85% = \$500.9	5
Amend	Treatment of dis performed) (Ana	location of knee, by closed reduction, inclues.) (Assist.)	ading application of external fixator (if
Fee 47054	Fee: \$337.95	<b>Benefit:</b> 75% = \$253.50 85% = \$287.3	0
Amend	Treatment of dis	location of patella, by closed reduction (Ar	naes.)
Fee 47057	Fee: \$132.20	<b>Benefit:</b> 75% = \$99.15 85% = \$112.40	
Amend	Treatment of dis	location of patella, by open reduction (Ana	nes.) (Assist.)
Fee 47060	Fee: \$176.35	<b>Benefit:</b> 75% = \$132.30 85% = \$149.9	0
Amend	Treatment of dis	location of ankle or tarsus, by closed reduc	ction (Anaes.) (Assist.)
Fee 47063	Fee: \$264.45	<b>Benefit:</b> 75% = \$198.35 85% = \$224.8	0
	Treatment of dis performed):	location of ankle or tarsus, by open reducti	on, including any of the following (if
	(a) arthrotomy;		
	(b) capsule repair;		
	(c) removal of loose fragments or intervening soft tissue;		
	(d) washout of joint		
<b>Amend</b> <b>Fee</b> 47066	(H) (Anaes.) (As	sist.)	

T8. SUR	GICAL OPERAT	IONS	15. ORTHOPAEDIC
	Fee: \$352.55	<b>Benefit:</b> 75% = \$264.45	
Amend Fee	Treatment of dis	location of toe, by open reduction-one to	e (Anaes.)
47069	Fee: \$73.55	<b>Benefit:</b> 75% = \$55.20 85% = \$62.55	
		TREATMENT OF FRA	CTURES
	Treatment of fra- bone (Anaes.)	cture of middle or proximal phalanx, by cl	osed reduction, requiring anaesthesia—one
<b>Amend</b> <b>Fee</b> 47301	(See para TN.8.12 <b>Fee:</b> \$90.30	4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$67.75 85% = \$76.80	
Amend	Treatment of fra-	cture of metacarpal, by closed reduction, re	equiring anaesthesia—one bone (H) (Anaes.)
<b>Fee</b> 47304	(See para TN.8.12 <b>Fee:</b> \$102.90	4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$77.20	
		cture of phalanx or metacarpal, by closed r rmed)—one bone (H) (Anaes.) (Assist.)	eduction, including percutaneous K-wire
Amend Fee 47307	(See para TN.8.12 <b>Fee:</b> \$208.10	4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$156.10	
	Treatment of fra (Assist.)	cture of phalanx or metacarpal, by open re	duction, with internal fixation (H) (Anaes.)
<b>Amend</b> <b>Fee</b> 47310	(See para TN.8.12 <b>Fee:</b> \$343.40	4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$257.55	
	Treatment of intr	ra-articular fracture of phalanx or metacarp	bal, by closed reduction, including:
	(a) percutaneous K-wire fixation; and		
	(b) external or d	ynamic fixation (if performed)	
Amond	(H) (Anaes.) (As	sist.)	
<b>Amend</b> <b>Fee</b> 47313	(See para TN.8.12 <b>Fee:</b> \$332.95	4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$249.75	
		ra-articular fracture of phalanx or metacarp ovided on the same occasion as a service t	
<b>Amend</b> <b>Fee</b> 47316	(See para TN.8.12 <b>Fee:</b> \$660.75	4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$495.60	
		ice provided on the same occasion as a ser	Idle phalanx, by open reduction, with fixation, vice to which item 47316 applies (H)
<b>Amend</b> <b>Fee</b> 47319	(See para TN.8.12 <b>Fee:</b> \$676.35	4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$507.30	
		cture of carpus (excluding scaphoid), by ca a service to which item 47351 applies	ast immobilisation, other than a service
Amend Fee	(Anaes.)		
47348	Fee: \$97.80	<b>Benefit:</b> 75% = \$73.35 85% = \$83.15	

T8. SUR	GICAL OPERATIO	ONS		15. ORTHOPAEDIC
Amend	Treatment of fract (Assist.)	ure of carpus (excluding s	caphoid), by open reduction, with int	ernal fixation (Anaes.)
Fee 47351	Fee: \$245.05	<b>Benefit:</b> 75% = \$183.80	85% = \$208.30	
<b>Amend</b> <b>Fee</b> 47354		ure of carpal scaphoid, by tem 47357 applies (Anaes <b>Benefit:</b> 75% = \$132.30		vice associated with a
47554			open reduction, with internal or perc	utaneous fixation
Amend Fee	(Anaes.) (Assist.)			
47357	Fee: \$391.80	<b>Benefit:</b> 75% = \$293.85		
Amend			or ulna (or both), by cast immobilisa em 47362, 47364, 47367, 47370 or 4	
<b>Fee</b> 47361	(See para TN.8.124 <b>Fee:</b> \$137.15	of explanatory notes to this <b>C</b> <b>Benefit:</b> 75% = \$102.90		
	Treatment of fracture of distal end of radius or ulna (or both), by closed reduction, requiring gene major regional anaesthesia, but excluding local infiltration, other than a service associated with a to which item 47361, 47364, 47367, 47370 or 47373 applies (Anaes.)		1 00	
<b>Amend</b> <b>Fee</b> 47362	(See para TN.8.124 <b>Fee:</b> \$205.60	of explanatory notes to this <b>C</b> <b>Benefit:</b> 75% = \$154.20		
	Treatment of fracture of distal end of radius or ulna (not involving joint surface), by open reduction w fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.)			
<b>Amend</b> <b>Fee</b> 47364	(See para TN.8.124 <b>Fee:</b> \$291.35	of explanatory notes to this <b>C</b> <b>Benefit:</b> 75% = \$218.55		
			, by closed reduction with percutaneo em 47361 or 47362 applies (H) (Anac	
<b>Amend</b> <b>Fee</b> 47367	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$232.70 <b>Benefit:</b> 75% = \$174.55			
			l end of radius, by open reduction wit em 47361 or 47362 applies (H) (Anac	
<b>Amend</b> <b>Fee</b> 47370	(See para TN.8.124 <b>Fee:</b> \$422.45	of explanatory notes to this C Benefit: 75% = \$316.85		
	Treatment of intra-articular fracture of distal end of ulna, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.)			
<b>Amend</b> <b>Fee</b> 47373	(See para TN.8.124 <b>Fee:</b> \$301.75	of explanatory notes to this <b>C</b> <b>Benefit:</b> 75% = \$226.35		
Amend Fee			na, by closed reduction (H) (Anaes.)	
47381	Fee: \$264.45	<b>Benefit:</b> 75% = \$198.35		
Amend Fee	Treatment of fract (Assist.)	ure of shaft of radius or ul	na, by open reduction with internal fi	ixation (H) (Anaes.)
47384	Fee: \$352.55	<b>Benefit:</b> 75% = \$264.45		

T8. SUR	GICAL OPERAT	IONS 15. ORTHOPAEDIC
	Treatment of:	
	(a) fracture of sh	aft of radius or ulna; and
	(b) dislocation of	f distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury);
Amend	by closed reduct	ion (H) (Anaes.) (Assist.)
<b>Fee</b> 47385	Fee: \$303.55	<b>Benefit:</b> 75% = \$227.70
47505	Treatment of:	
	(a) fracture of sh	aft of radius or ulna; and
	(b) dislocation of	f distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury);
Amend Fee	by open reductio (Assist.)	n, with internal fixation, including reduction of dislocation (if performed) (H) (Anaes.)
47386	Fee: \$489.75	<b>Benefit:</b> 75% = \$367.35
Amend		cture of distal or shaft of radius or ulna (or both), by cast immobilisation, other than a item 47390 or 47393 applies (Anaes.) (Assist.)
<b>Fee</b> 47387	Fee: \$284.00	<b>Benefit:</b> 75% = \$213.00 85% = \$241.40
Amend	Treatment of frac	cture of shafts of radius and ulna, by closed reduction (H) (Anaes.)
<b>Fee</b> 47390	Fee: \$426.15	<b>Benefit:</b> 75% = \$319.65
Amend	Treatment of fraction (Assist.)	cture of shafts of radius and ulna, by open reduction, with internal fixation (H) (Anaes.)
<b>Fee</b> 47393	Fee: \$568.10	<b>Benefit:</b> 75% = \$426.10
Amend	Treatment of fra	cture of olecranon, by closed reduction (Anaes.)
<b>Fee</b> 47396	Fee: \$195.80	<b>Benefit:</b> 75% = \$146.85 85% = \$166.45
Amend	Treatment of frac	cture of olecranon, by open reduction (H) (Anaes.) (Assist.)
<b>Fee</b> 47399	Fee: \$391.80	<b>Benefit:</b> 75% = \$293.85
Amend	Treatment of fracture of olecranon, with excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.)	
<b>Fee</b> 47402	Fee: \$293.75	<b>Benefit:</b> 75% = \$220.35 85% = \$249.70
Amend	Treatment of frac	cture of head or neck of radius, by closed reduction (Anaes.)
<b>Fee</b> 47405	Fee: \$195.80	<b>Benefit:</b> 75% = \$146.85 85% = \$166.45
Amend	Treatment of fracture of head or neck of radius, by open reduction, including internal fixation and excision (if performed) (H) (Anaes.) (Assist.)	
<b>Fee</b> 47408	Fee: \$391.80	<b>Benefit:</b> 75% = \$293.85
Amend	Treatment of frac (Anaes.)	cture of tuberosity of humerus, other than a service to which item 47417 applies
<b>Fee</b> 47411	Fee: \$117.40	<b>Benefit:</b> 75% = \$88.05 85% = \$99.80

T8. SUR	GICAL OPERATIO	DNS 15. ORTHO	PAEDIC
Amend	Treatment of fract	ure of tuberosity of humerus, by open reduction (Anaes.)	
<b>Fee</b> 47414	Fee: \$235.15	<b>Benefit:</b> 75% = \$176.40 85% = \$199.90	
Amend Fee	Treatment of fract reduction (Anaes.)	ure of tuberosity of humerus and associated dislocation of shoulder, by closed (Assist.)	1
47417	Fee: \$274.25	<b>Benefit:</b> 75% = \$205.70 85% = \$233.15	
Amend Fee	Treatment of fract (H) (Anaes.) (Assi	ure of tuberosity of humerus and associated dislocation of shoulder, by open 1 st.)	reduction
47420	Fee: \$538.80	<b>Benefit:</b> 75% = \$404.10	
Amend Fee	Humerus, proxima applies (Anaes.)	al, treatment of fracture of, other than a service to which item 47426, 47429 of	r 47432
47423	Fee: \$225.25	<b>Benefit:</b> 75% = \$168.95 85% = \$191.50	
Amend Fee	Humerus, proxima	l, treatment of fracture of, by closed reduction (H) (Anaes.)	
47426	Fee: \$337.95	<b>Benefit:</b> 85% = \$287.30	
Amend	Humerus, proxima	l, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	
Fee 47429	Fee: \$450.50	<b>Benefit:</b> 75% = \$337.90	
Amend	Humerus, proxima	I, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	
<b>Fee</b> 47432	Fee: \$563.20	<b>Benefit:</b> 75% = \$422.40	
Amend	Humerus, proxima (Anaes.) (Assist.)	al, treatment of fracture of, and associated dislocation of shoulder, by closed re	eduction
Fee 47435	Fee: \$431.05	<b>Benefit:</b> 75% = \$323.30 100% = \$431.05	
Amend	Humerus, proxima (H) (Anaes.) (Assi	al, treatment of fracture of, and associated dislocation of shoulder, by open rec st.)	luction
Fee 47438	Fee: \$685.85	<b>Benefit:</b> 75% = \$514.40	
Amend		al, treatment of intra-articular fracture of, and associated dislocation of should ) (Anaes.) (Assist.)	er, by
<b>Fee</b> 47441	Fee: \$857.15	<b>Benefit:</b> 75% = \$642.90	
Amend	Humerus, shaft of, treatment of fracture of, other than a service to which item 47447 or 47450 applies (Anaes.)		
<b>Fee</b> 47444	Fee: \$235.15	<b>Benefit:</b> 75% = \$176.40 85% = \$199.90	
Amend Fee		treatment of fracture of, by closed reduction (H) (Anaes.)	
47447	<b>Fee:</b> \$352.55	<b>Benefit:</b> 75% = \$264.45	
Amend Fee		treatment of fracture of, by internal or external (H) (Anaes.) (Assist.)	
47450	Fee: \$470.30	<b>Benefit:</b> 75% = \$352.75	
Amend Fee	Humerus, shaft of,	treatment of fracture of, by intramedullary fixation (H) (Anaes.) (Assist.)	
47451	Fee: \$566.85	<b>Benefit:</b> 75% = \$425.15	
Amend	Humerus, distal, (s	supracondylar or condylar), treatment of fracture of, other than a service to whether the service to whether the service to whether the service to be servic	hich

T8. SUR	GICAL OPERATIONS			15. ORTHOPAEDIC
<b>Fee</b> 47453	item 47456 or 47459 a	pplies (Anaes.) (Assis	t.)	
	<b>Fee:</b> \$274.25 <b>B</b>	<b>enefit:</b> 75% = \$205.70	85% = \$233.15	
Amend Fee	Humerus, distal (supra (Assist.)	condylar or condylar).	, treatment of fracture of, by closed re	eduction (H) (Anaes.)
47456	<b>Fee:</b> \$411.55 <b>B</b>	<b>enefit:</b> 75% = \$308.70		
Amend Fee	Humerus, distal (supra (Assist.)	condylar or condylar).	, treatment of fracture of, by open red	luction (H) (Anaes.)
47459	<b>Fee:</b> \$548.65 <b>B</b>	<b>enefit:</b> 75% = \$411.50		
Amend Fee			a service to which item 47465 applie	s (Anaes.)
47462		enefit: 75% = \$88.05		
Amend Eas	Clavicle, treatment of	fracture of, by open re	duction (Anaes.) (Assist.)	
<b>Fee</b> 47465	Fee: \$538.80 B	enefit: 75% = \$404.10	85% = \$458.00	
Amend Fee	Sternum, treatment of	fracture of, other than	a service to which item 47467 applie	es (Anaes.)
47466	<b>Fee:</b> \$117.40 <b>B</b>	<b>enefit:</b> 75% = \$88.05	85% = \$99.80	
Amend	Sternum, treatment of	fracture of, by open re	duction (H) (Anaes.)	
<b>Fee</b> 47467	Fee: \$235.15 B	<b>enefit:</b> 75% = \$176.40		
	SCAPULA, neck or gl	enoid region of, treatn	nent of fracture of, by open reduction	(Anaes.) (Assist.)
<b>Fee</b> 47468	Fee: \$450.50 B	<b>enefit:</b> 75% = \$337.90	85% = \$382.95	
Amend	RIBS (one or more), tr	eatment of fracture of	- each attendance	
<b>Fee</b> 47471	<b>Fee:</b> \$44.75 <b>B</b>	enefit: 75% = \$33.60	85% = \$38.05	
	PELVIC RING, treatm	ent of fracture of, not	involving disruption of pelvic ring of	r acetabulum
Fee 47474	Fee: \$195.80 B	enefit: 75% = \$146.85	85% = \$166.45	
		ent of fracture of, with	h disruption of pelvic ring or acetabu	lum
Fee		<b>enefit:</b> 75% = \$183.80		
4/4// Amend			uiring traction (H) (Anaes.) (Assist.)	
<b>Fee</b> 47480		enefit: 75% = \$367.35	uning fraction (11) (Anaes.) (Assist.)	
Amend	PELVIC RING, treatm	ent of fracture of, requ	uiring control by external fixation (H	) (Anaes.) (Assist.)
<b>Fee</b> 47483	<b>Fee:</b> \$587.75 <b>B</b>	enefit: 75% = \$440.85		
	Treatment of fracture of anterior pelvic ring or sacroiliac joint disruption (or both), by open reduction		), by open reduction,	
Amend	with internal fixation (H) (Anaes.) (Assist.)			
<b>Fee</b> 47486	<b>Fee:</b> \$979.60 <b>B</b>	enefit: 75% = \$734.70		
Amend	Treatment of fracture of with internal fixation (		or sacroiliac joint disruption (or both	h), by open reduction,
<b>Fee</b> 47489	<b>Fee:</b> \$1,469.40 <b>B</b>	enefit: 75% = \$1102.05	5	
Amend	Treatment of fracture of	of acetabulum and asso	ociated dislocation of hip, including t	he application and

T8. SUR	GICAL OPERATI	ONS 15. ORTHOPAEDIC
<b>Fee</b> 47495	management of tr	action (if performed), excluding aftercare (Anaes.) (Assist.)
47495	Fee: \$489.75	<b>Benefit:</b> 75% = \$367.35 85% = \$416.30
Amend		ated posterior wall fracture of acetabulum and associated dislocation of hip, by open ternal fixation, including the application and management of traction (if performed) ist.)
Fee 47498	Fee: \$734.65	<b>Benefit:</b> 75% = \$551.00
		rior or posterior column fracture of acetabulum, by open reduction, with internal g any of the following (if performed):
	(a) capsular stabil	isation;
	(b) capsulotomy;	
	(c) osteotomy	
Amend Fee	(H) (Anaes.) (Ass	ist.)
47501	Fee: \$979.60	<b>Benefit:</b> 75% = \$734.70
	fractures of acetal	bined column T-Type, transverse, anterior column or posterior hemitransverse bulum, by open reduction, with internal fixation, performed through single or dual ng fixation of the posterior wall fracture), including any of the following (if isation;
	(b) capsulotomy;	
	(c) osteotomy	
	(H) (Anaes.) (Ass	ict )
<b>New</b> 47511	<b>Fee:</b> \$1,469.40	<b>Benefit:</b> 75% = \$1102.05
		erior wall fracture of acetabulum and associated femoral head fracture, by open ternal fixation (H) (Anaes.) (Assist.)
<b>New</b> 47514	Fee: \$857.15	<b>Benefit:</b> 75% = \$642.90
	FEMUR, treatme	nt of fracture of, by closed reduction or traction (Anaes.) (Assist.)
Fee 47516	Fee: \$450.50	<b>Benefit:</b> 75% = \$337.90 85% = \$382.95
Amend	FEMUR, treatme	nt of trochanteric or subcapital fracture of, by internal fixation (H) (Anaes.) (Assist.)
Fee 47519	Fee: \$901.30	<b>Benefit:</b> 75% = \$676.00
Amend Fee	FEMUR, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.)	
47528	Fee: \$783.80	<b>Benefit:</b> 75% = \$587.85
Amend Fee	FEMUR, treatmer (Assist.)	nt of fracture of shaft, by intramedullary fixation and cross fixation (H) (Anaes.)
47531	Fee: \$999.15	<b>Benefit:</b> 75% = \$749.40
Amend Fee	Femur, condylar	region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal

T8. SUR	GICAL OPERATIO	ONS	15. ORTHOPAEDIC	
47534	fixation, with or without internal fixation of one or more osteochondral fragments (H) (Anaes.		e osteochondral fragments (H) (Anaes.) (Assist.)	
	Fee: \$1,126.55	<b>Benefit:</b> 75% = \$844.95		
Amend Fee	osteochondral frag (Anaes.) (Assist.)	gion of, treatment of fracture of, requ ments, other than a service associated	iring internal fixation of one or more with a service to which item 47534 applies	
47537	Fee: \$450.50	<b>Benefit:</b> 75% = \$337.90 85% = \$38		
Amend Fee 47540	Hip spica or shoul Fee: \$225.25	der spica, application of, as an indepen <b>Benefit:</b> 75% = \$168.95 85% = \$19	· · · ·	
Amend		reatment of medial or lateral fracture	of, other than a service to which item 47546 or	
<b>Fee</b> 47543	Fee: \$235.15	<b>Benefit:</b> 75% = \$176.40 85% = \$19	9.90	
Amend Fee	Tibia, plateau of, t	reatment of medial or lateral fracture	of, by closed reduction (Anaes.)	
47546	Fee: \$352.55	<b>Benefit:</b> 75% = \$264.45 85% = \$29	9.70	
	including any of th	al or lateral fracture of plateau of tibia e following (if performed):	a, by open reduction, with internal fixation,	
	(a) arthroscopy;			
	(b) arthrotomy;			
	(c) meniscal repair			
Amend Fee	(H) (Anaes.) (Assi	st.)		
47549	Fee: \$560.05	<b>Benefit:</b> 75% = \$420.05		
Amend Fee		reatment of both medial and lateral fra 58 applies (Anaes.) (Assist.)	actures of, other than a service to which	
47552	Fee: \$391.80	<b>Benefit:</b> 75% = \$293.85 85% = \$33	3.05	
Amend Fee	Tibia, plateau of, t	reatment of both medial and lateral fra	actures of, by closed reduction (H) (Anaes.)	
47555	Fee: \$587.75	<b>Benefit:</b> 75% = \$440.85		
	Treatment of mediany of the following		en reduction, with internal fixation, including	
	(a) arthroscopy;			
	(b) arthrotomy;			
	(c) meniscal repair			
Amend Fee	(H) (Anaes.) (Assist.)			
47558	Fee: \$1,038.40	<b>Benefit:</b> 75% = \$778.80		
		al or lateral (or both) fracture of plate the plateau (Anaes.) (Assist.)	au of tibia, with application of a bridging	
<b>New</b> 47559	Fee: \$795.25	<b>Benefit:</b> 75% = \$596.45 85% = \$71	0.55	

T8. SUR	GICAL OPERATI	ONS 15. ORTHOPAEDI	
Amend Fee	Treatment of frac or 47573 applies	ture of shaft of tibia, by cast immobilisation, other than a service to which item 47570 (Anaes.)	
47561	Fee: \$284.00	<b>Benefit:</b> 75% = \$213.00 85% = \$241.40	
Amend	Tibia, shaft of, tre	atment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.)	
<b>Fee</b> 47565	Fee: \$741.25	<b>Benefit:</b> 75% = \$555.95	
Amend Fee	Tibia, shaft of, tro (Assist.)	atment of fracture of, by intramedullary fixation and cross fixation (H) (Anaes.)	
47566	Fee: \$944.90	<b>Benefit:</b> 75% = \$708.70	
	Closed reduction fracture (Anaes.)	of proximal tibia, distal tibia or shaft of tibia, with or without treatment of fibular (Assist.)	
<b>New</b> 47568	Fee: \$426.15	<b>Benefit:</b> 75% = \$319.65 85% = \$362.25	
Amend Fee	Tibia, shaft of, tro (Anaes.) (Assist.)	atment of fracture of, by open reduction, with or without treatment of fibular fracture	
47570	Fee: \$568.10	<b>Benefit:</b> 75% = \$426.10 85% = \$483.40	
		imal or distal intra-articular fracture of shaft of tibia, by open reduction, with or of fibular fracture, including any of the following (if performed):	
	(b) arthrotomy;		
	(c) capsule repair		
	(d) removal of intervening soft tissue;		
	(e) removal of loose fragments;		
	(f) washout of joi	nt;	
Amend		ce associated with a service to which another item in this Schedule applies if the in the other item is for the purpose of treating a medial malleolus fracture of the distal (Assist.)	
<b>Fee</b> 47573	Fee: \$710.20	<b>Benefit:</b> 75% = \$532.65	
Amend Fee	Treatment of frac	ture of patella, other than a service to which item 47582 or 47585 applies (Anaes.)	
47579	Fee: \$166.55	<b>Benefit:</b> 75% = \$124.95 85% = \$141.60	
Amend Fee	Treatment of fracture of patella, with internal fixation, including bone grafting (if performed), other than a service associated with a service to which item 47579 or 47585 applies (H) (Anaes.) (Assist.)		
47582	Fee: \$440.95	<b>Benefit:</b> 75% = \$330.75	
		imal or distal fracture of patella, by open reduction, with internal fixation, including ng (if performed):	
	(a) arthrotomy;		
Amend Fee 47585	(b) excision of pa	tellar pole, with reattachment of tendon;	

T8. SUR	GICAL OPERATI	DNS 15. ORTHOPAEDIC		
	(c) removal of loc	se fragments;		
	(d) repair of quad	iceps or patellar tendon (or both);		
	(e) stabilisation of	patello-femoral joint		
	(H) (Anaes.) (Ass	st.)		
	Fee: \$455.85	<b>Benefit:</b> 75% = \$341.90		
Amend Fee		ent of fracture of, by internal fixation of intra-articular fractures of femoral condylar or aces and requiring repair or reconstruction of one or more ligaments (H) (Anaes.)		
47588	Fee: \$1,371.25	<b>Benefit:</b> 75% = \$1028.45		
Amend Fee		ent of fracture of, by internal fixation of intra-articular fractures of femoral condylar surfaces and requiring repair or reconstruction of one or more ligaments (H) (Anaes.)		
47591	Fee: \$1,665.50	<b>Benefit:</b> 75% = \$1249.15		
		action (or both) of acute traumatic chondral injury to the distal femoral and proximal faces of the knee, using chondral or osteochondral implants or transfers (H) (Anaes.)		
<b>New</b> 47593	Fee: \$830.30	<b>Benefit:</b> 75% = \$622.75		
	Treatment of frac management—on	ure of ankle joint, hindfoot, midfoot, metatarsals or toes, by non-surgical e leg (Anaes.)		
<b>New</b> 47595	Fee: \$167.60	<b>Benefit:</b> 75% = \$125.70 85% = \$142.50		
Amend	Treatment of frac	are of ankle joint, by closed reduction (Anaes.) (Assist.)		
<b>Fee</b> 47597	Fee: \$337.95	<b>Benefit:</b> 75% = \$253.50 85% = \$287.30		
	Treatment of frac	are of ankle joint:		
	(a) by internal fixation of the malleolus, fibula or diastasis; and			
	(b) including any of the following (if performed):			
	(i) arthrotomy;			
	(ii) capsule repair;			
	(iii) removal of loose fragments or intervening soft tissue;			
	(iv) washou	of joint		
Amend	(H) (Anaes.) (Ass			
<b>Fee</b> 47600	Fee: \$587.75	<b>Benefit:</b> 75% = \$440.85		
.,	Treatment of frac			
<b>Amend</b> <b>Fee</b> 47603		tion of 2 or more of the malleolus, fibula, diastasis and medial tissue interposition;		

T8. SUR	GICAL OPERAT	<b>FIONS</b>	15. ORTHOPAEDIC
	(b) including any	y of the following (if performed):	
	(i) arthroto	omy;	
	(ii) capsule repair;		
	(iii) removal of loose fragments or intervening soft tissue;		
	(iv) washo	out of joint	
	(H) (Anaes.) (As	ssist.)	
	Fee: \$741.25	<b>Benefit:</b> 75% = \$555.95	
Amend Fee	Treatment of intr foot (Anaes.) (A	tra-articular fracture of hindfoot, by closed reduction, with or v	vithout dislocation—one
47612	Fee: \$426.15	<b>Benefit:</b> 75% = \$319.65 85% = \$362.25	
	Treatment of fra- following (if per	acture of hindfoot, by open reduction, with or without dislocati rformed):	on, including any of the
	(a) arthrotomy;		
	(b) capsule repai	ir;	
	(c) removal of lo	oose fragments or intervening soft tissue;	
	(d) washout of jo	oint	
Amend	—one foot (Ana	aes.) (Assist.)	
<b>Fee</b> 47615	Fee: \$489.75	<b>Benefit:</b> 75% = \$367.35 85% = \$416.30	
		tra-articular fracture of hindfoot, by open reduction, with or wi uding any of the following (if performed):	thout
	(a) arthrotomy;		
	(b) capsule repai	ir;	
	(c) removal of lo	pose fragments or intervening soft tissue;	
	(d) washout of joint		
Amend	—one foot (H) (.	(Anaes.) (Assist.)	
<b>Fee</b> 47618	Fee: \$612.25	<b>Benefit:</b> 75% = \$459.20	
Amend	Treatment of intr foot (Anaes.) (A	tra-articular fracture of midfoot, by closed reduction, with or wassist.)	vithout dislocation—one
<b>Fee</b> 47621	Fee: \$426.15	<b>Benefit:</b> 75% = \$319.65 85% = \$362.25	
	Treatment of fra of the following	acture of tarso-metatarsal, by open reduction, with or without d (if performed):	lislocation, including any
Amend Fee 47624	(a) arthrotomy;		

T8. SUR	GICAL OPERATIO	NS 15. ORTHOPAEDIC
	(b) capsule or ligan	ent repair;
	(c) removal of loos	e fragments or intervening soft tissue;
	(d) washout of join	
	—one joint (H) (Ar	aes.) (Assist.)
	Fee: \$587.75	<b>Benefit:</b> 75% = \$440.85
	Treatment of fractu following (if perfor	re of cuneiform, by open reduction, with or without dislocation, including any of the med):
	(a) arthrotomy;	
	(b) capsule or ligan	ent repair;
	(c) removal of loos	e fragments or intervening soft tissue;
	(d) washout of join	
Amend	—one bone (Anaes	) (Assist.)
Fee 47630	<b>Fee:</b> \$352.55	<b>Benefit:</b> 75% = \$264.45 85% = \$299.70
	Treatment of fractu (Assist.)	res of metatarsal, by closed reduction—one or more metatarsals of one foot (Anaes.)
<b>New</b> 47637	Fee: \$199.60	<b>Benefit:</b> 75% = \$149.70 85% = \$169.70
Amend		re of metatarsal, by open reduction, including removal of loose fragments or ue (if performed)—one metatarsal (Anaes.) (Assist.)
Fee 47639	Fee: \$235.15	<b>Benefit:</b> 75% = \$176.40 85% = \$199.90
Amend		re of metatarsal, by open reduction, including removal of loose fragments or ue (if performed)—2 metatarsals of one foot (H) (Anaes.) (Assist.)
Fee 47648	Fee: \$313.25	<b>Benefit:</b> 75% = \$234.95
Amend Fee		re of metatarsal, by open reduction, including removal of loose fragments or ue (if performed)—3 or more metatarsals of one foot (H) (Anaes.) (Assist.)
47657	Fee: \$489.75	<b>Benefit:</b> 75% = \$367.35
Amend Fee	Treatment of fractu	re of phalanx of toe, by closed reduction—one toe (Anaes.)
47663	Fee: \$146.95	<b>Benefit:</b> 75% = \$110.25 85% = \$124.95
	Treatment of fractu following (if perfor	re or dislocation of phalanx of great toe, by open reduction, including any of the med):
	(a) arthrotomy;	
	(b) capsule repair;	
	(c) removal of loos	e fragments;
<b>Amend</b> <b>Fee</b> 47666	(d) removal of inter	vening soft tissue;

T8. SUR	GICAL OPERAT	ONS 15. ORTHOPAEDIC
	(e) washout of jo	nt
	— one great toe	Anaes.)
	Fee: \$245.05	<b>Benefit:</b> 75% = \$183.80 85% = \$208.30
	Treatment of frac (if performed):	ture or dislocation of phalanx of toe, by open reduction, including any of the following
	(a) arthrotomy;	
	(b) capsule repair	
	(c) removal of lo	se fragments;
	(d) removal of in	ervening soft tissue;
	(e) washout of jo	nt
Amend	—one toe (other	han great toe) of one foot (Anaes.)
<b>Fee</b> 47672	Fee: \$117.40	<b>Benefit:</b> 75% = \$88.05 85% = \$99.80
	Treatment of frac (if performed):	ture or dislocation of phalanx of toe, by open reduction, including any of the following
	(a) arthrotomy;	
	(b) capsule repai	;
	(c) removal of lo	se fragments;
	(d) removal of in	ervening soft tissue;
	(e) washout of jo	nt
Amend	—2 or more toes	(other than great toe) of one foot (Anaes.)
<b>Fee</b> 47678	Fee: \$176.35	<b>Benefit:</b> 75% = \$132.30 85% = \$149.90
Amend Fee	Nasal bones, trea attendance	ment of fracture of, other than a service to which item 47738 or 47741 applies—each
47735	Fee: \$44.80	<b>Benefit:</b> 75% = \$33.60 85% = \$38.10
Amend Fee	Nasal bones, trea	ment of fracture of, by reduction (Anaes.)
47738	Fee: \$245.05	<b>Benefit:</b> 75% = \$183.80 85% = \$208.30
Amend Fee	Nasal bones, trea	ment of fracture of, by open reduction involving osteotomies (H) (Anaes.) (Assist.)
47741	Fee: \$499.80	<b>Benefit:</b> 75% = \$374.85
Amend Fee	Maxilla, treatmen fixation (H) (Ana	t of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external es.) (Assist.)
Fee 47753	Fee: \$423.10	<b>Benefit:</b> 75% = \$317.35
<b>Amend</b> <b>Fee</b> 47756		ent of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or H) (Anaes.) (Assist.)

T8. SUR	GICAL OPERATI	ONS 15. ORTHOPAEDIC	
	Fee: \$423.10	<b>Benefit:</b> 75% = \$317.35	
Amend Fee	Zygomatic bone, approach (Anaes.	treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other	
47762	Fee: \$248.45	<b>Benefit:</b> 75% = \$186.35 85% = \$211.20	
Amend Fee		treatment of fracture of, requiring surgical reduction and involving internal or external H) (Anaes.) (Assist.)	
47765	Fee: \$408.00	<b>Benefit:</b> 75% = \$306.00	
Amend Fee		treatment of fracture of, requiring surgical reduction and involving internal or external 2 sites (H) (Anaes.) (Assist.)	
47768	Fee: \$499.80	<b>Benefit:</b> 75% = \$374.85	
Amend Fee		treatment of fracture of, requiring surgical reduction and involving internal or external 3 sites (H) (Anaes.) (Assist.)	
47771	Fee: \$574.20	<b>Benefit:</b> 75% = \$430.65	
Amend Fee	Maxilla, treatmen	t of fracture of, requiring open operation (H) (Anaes.) (Assist.)	
47774	Fee: \$453.30	<b>Benefit:</b> 75% = \$340.00	
Amend Fee	Mandible, treatme	ent of fracture of, requiring open reduction (H) (Anaes.) (Assist.)	
47777	Fee: \$453.30	<b>Benefit:</b> 75% = \$340.00	
Amend Fee	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving plate (H) (Anaes.) (Assist.)		
47780	Fee: \$589.30	<b>Benefit:</b> 75% = \$442.00	
Amend Fee	Mandible, treatme (Anaes.) (Assist.)	ent of fracture of, requiring open reduction and internal fixation not involving plate	
47783	Fee: \$589.30	<b>Benefit:</b> 75% = \$442.00 85% = \$504.60	
Amend	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving plate (H) (Anaes.) (Assist.)		
<b>Fee</b> 47786	Fee: \$747.85	<b>Benefit:</b> 75% = \$560.90	
Amend Fee	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving plate (H) (Anaes.) (Assist.)		
47789	Fee: \$747.85	<b>Benefit:</b> 75% = \$560.90	
		GENERAL OPERATIONS	
Amend Fee	Injection into, or aspiration of, unicameral bone cyst (Anaes.)		
47900	Fee: \$176.35	<b>Benefit:</b> 75% = \$132.30 85% = \$149.90	
Amend Fee	Epicondylitis, ope	Epicondylitis, open operation for (Anaes.)	
47903	Fee: \$245.05	<b>Benefit:</b> 75% = \$183.80 85% = \$208.30	
Amend Fee	Digital nail of toe	, removal of, not being a service to which item 47906 applies (Anaes.)	
47904	Fee: \$58.75	<b>Benefit:</b> 75% = \$44.10 85% = \$49.95	

GICAL OPERAT	ONS	15. ORTHOPAEDIC	
Digital nail of too	e, removal of, in the operating theatre of a hospital (H) (Ana	nes.)	
Fee: \$117.40	<b>Benefit:</b> 75% = \$88.05		
Wedge resection	for ingrowing nail of toe:		
(a) including each	n of the following:		
(i) removal	of segment of nail;		
(ii) remova	of ungual fold;		
(iii) excisio	n and partial ablation of germinal matrix and portion of nail	bed; and	
(b) including phe	nolisation (if performed)		
(Anaes.) (Assist	.)		
Fee: \$176.35	<b>Benefit:</b> 75% = \$132.30 85% = \$149.90		
Fee: \$88.60	<b>Benefit:</b> 75% = \$66.45 85% = \$75.35		
-			
(a) including each of the following:			
(i) removal of segment of nail;			
(ii) removal of ungual fold;			
(iii) excisio	n and ablation of germinal matrix and portion of nail bed; a	nd	
(b) including phenolisation (if performed)			
(Anaes.) (Assist	.)		
Fee: \$245.05	<b>Benefit:</b> 75% = \$183.80 85% = \$208.30		
Orthopaedic pin	or wire, insertion of, as an independent procedure (Anaes.)		
Fee: \$117.40	<b>Benefit:</b> 75% = \$88.05 85% = \$99.80		
	an a service associated with a service to which item 47927 of	or 47929 applies—one bone	
	<b>Benefit:</b> 75% - \$29.40 85% - \$33.30		
		xation purposes)—one bone	
(H) (Anaes.)		• • <i>′</i>	
Fee: \$146.95	<b>Benefit:</b> 75% = \$110.25		
fixation), other th	an a service associated with a service to which item 47924	-	
Fee: \$391.80	<b>Benefit:</b> 75% = \$293.85		
	Digital nail of too Fee: \$117.40 Wedge resection (a) including each (i) removal (ii) removal (iii) excision (b) including phe (Anaes.) (Assist Fee: \$176.35 Partial resection f Fee: \$88.60 Complete ablatio (a) including each (i) removal (ii) removal (ii) removal (ii) excision (b) including phe (Anaes.) (Assist Fee: \$245.05 Orthopaedic pin of Fee: \$117.40 Removal of one of incision, other that (Anaes.) Fee: \$39.15 Removal of fix att fixation), other that (H) (Anaes.) (Assist	<ul> <li>Wedge resection for ingrowing nail of toe: <ul> <li>(a) including each of the following:</li> <li>(i) removal of segment of nail;</li> <li>(ii) removal of ungual fold;</li> <li>(iii) excision and partial ablation of germinal matrix and portion of nail</li> <li>(b) including phenolisation (if performed)</li> <li>(Anaes.) (Assist.)</li> </ul> </li> <li>Fee: \$176.35 Benefit: 75% = \$132.30 85% = \$149.90</li> <li>Partial resection for ingrowing nail of toe, including phenolisation (Anaes.)</li> <li>Fee: \$88.60 Benefit: 75% = \$66.45 85% = \$75.35</li> <li>Complete ablation of nail germinal matrix:</li> <li>(a) including each of the following: <ul> <li>(i) removal of segment of nail;</li> <li>(ii) removal of segment of nail;</li> <li>(iii) excision and ablation of germinal matrix and portion of nail bed; a</li> <li>(b) including phenolisation (if performed)</li> <li>(Anaes.) (Assist.)</li> </ul> </li> <li>Fee: \$245.05 Benefit: 75% = \$183.80 85% = \$208.30</li> <li>Orthopaedic pin or wire, insertion of, as an independent procedure (Anaes.)</li> <li>Fee: \$117.40 Benefit: 75% = \$88.05 85% = \$99.80</li> <li>Removal of one or more buried wires, pins or screws (inserted for internal finitosion, other than a service associated with a service to which item 47927 (Anaes.)</li> <li>Fee: \$146.95 Benefit: 75% = \$110.25</li> <li>Removal of fixation elements (including plate, rod or nail and associated wirfixation), other than a service associated with a service to which item 47924 (H) (Anaes.) (Assist.)</li> </ul>	

T8. SUR	GICAL OPERATIO	ONS		15. ORTHOPAEDIC
	Repair of distal bi (Assist.)	ceps brachii tendon, by an	y method, performed as an indepen	dent procedure (Anaes.)
<b>New</b> 47953	Fee: \$450.50	<b>Benefit:</b> 75% = \$337.90	85% = \$382.95	
	Repair of traumati	c tear or rupture of tendor	n, other than a service associated wi	th:
	(a) a service to wh	ich item 39330 applies; or	r	
Amend Fee			chedule applies if the service decrib ms in the same region (Anaes.) (As	
47954	Fee: \$391.80	<b>Benefit:</b> 75% = \$293.85	5 85% = \$333.05	
			by open or arthroscopic means, when both of the following (if performed)	
	(a) bursectomy;			
	(b) preparation of	greater trochanter;		
			e to which another item in this Sche purpose of performing a procedure	
<b>New</b> 47955	Fee: \$678.05	<b>Benefit:</b> 75% = \$508.55	i	
	associated with a s	service to which another it	rmed as an independent procedure, o tem in this Schedule applies if the so a procedure on the hip (H) (Anaes.)	ervice described in the
<b>New</b> 47956	Fee: \$1,017.05	<b>Benefit:</b> 75% = \$762.80	)	
	TENOTOMY, SU (Anaes.)	BCUTANEOUS, not beir	ng a service to which another item i	n this Group applies
47960	Fee: \$135.95	<b>Benefit:</b> 75% = \$102.00	85% = \$115.60	
	than a service asso	ociated with a service to w	means, when performed as an inder which another item in this Schedule a e of performing a procedure on the	applies if the service
<b>New</b> 47964	Fee: \$225.25	<b>Benefit:</b> 75% = \$168.95	;	
		• •	nuscle tendon transfer, including ass stomosis and biceps tenodesis—one	
<b>New</b> 47967	Fee: \$450.50	<b>Benefit:</b> 75% = \$337.90	)	
Amend Fee		ecompression fasciotomy issue (H) (Anaes.) (Assist.	of, for acute compartment syndrom .)	e, requiring excision of
47975	Fee: \$384.15	<b>Benefit:</b> 75% = \$288.15	;	
Amend	Forearm or calf, d muscle and deep t		of, for chronic compartment syndro	ome, requiring excision of
<b>Fee</b> 47978	Fee: \$233.30	<b>Benefit:</b> 75% = \$175.00	)	
Amend	Forearm, calf or in	nterosseous muscle space of	of hand, decompression fasciotomy	of, other than a service

T8. SUR	GICAL OPERAT	ONS 15. ORTHOPAEDIC		
<b>Fee</b> 47981	to which another item in this Group applies (Anaes.)			
	Fee: \$156.65	<b>Benefit:</b> 75% = \$117.50 85% = \$133.20		
Amend Fee	Forage (Drill de	ompression), of neck or head of femur, or both (H) (Anaes.) (Assist.)		
47982	Fee: \$379.70	<b>Benefit:</b> 75% = \$284.80		
New	Stabilisation of s	pped capital femoral epiphysis, by internal fixation (H) (Anaes.) (Assist.)		
47983	Fee: \$901.30	<b>Benefit:</b> 75% = \$676.00		
		ealignment of slipped capital femoral epiphysis, other than a service associated with a tem 48427 applies (H) (Anaes.) (Assist.)		
<b>New</b> 47984	Fee: \$901.30	<b>Benefit:</b> 75% = \$676.00		
		BONE GRAFTS		
	Harvesting and (H) (Anaes.) (As	sertion of bone graft (autograft) via separate incisions and at separate surgical fields ist.)		
<b>New</b> 48245	Fee: \$325.45	<b>Benefit:</b> 75% = \$244.10		
		sertion of bone graft (autograft) via separate incisions, including internal fixation of the ation (or both) (H) (Anaes.) (Assist.)		
<b>New</b> 48248	Fee: \$504.00	<b>Benefit:</b> 75% = \$378.00		
	-	sertion of osteochondral graft (autograft) via separate incisions at the same joint or (Anaes.) (Assist.)		
<b>New</b> 48251	Fee: \$414.75	<b>Benefit:</b> 75% = \$311.10		
		sertion of pedicled bone flap (autograft), including internal fixation of the bone flap (if than a service associated with a service to which item 45562, 45504 or 45505 applies ist.)		
<b>New</b> 48254	Fee: \$950.25	<b>Benefit:</b> 75% = \$712.70		
	Preparation and insertion of metallic, cortical or other graft substitute (allograft), where substitute is structural cortico-cancellous bone or structural bone (or both), including internal fixation (if performed) (H) (Anaes.) (Assist.)			
<b>New</b> 48257	Fee: \$414.75	<b>Benefit:</b> 75% = \$311.10		
		OSTEOTOMY AND OSTEECTOMY		
		lanx or metatarsal of foot, for correction of deformity, excision of accessory bone or cluding any of the following (if performed):		
(a) removal of bone;		1e;		
	(b) excision of surrounding osteophytes;			
	(c) synovectomy			
	(d) joint release;			
Amend Fee	—one bone (H)	Anaes.) (Assist.)		
48400	Fee: \$342.90	<b>Benefit:</b> 75% = \$257.20		

T8. SUR	GICAL OPERAT	IONS	15. ORTHOPAEDIC
		alanx or metatarsal of first toe of foot, fing any of the following (if performed):	or correction of deformity, with internal
	(a) removal of be	one;	
	(b) excision of su	urrounding osteophytes;	
	(c) synovectomy	;	
	(d) joint release;		
Amend	—one bone (H)	(Anaes.) (Assist.)	
<b>Fee</b> 48403	Fee: \$538.80	<b>Benefit:</b> 75% = \$404.10	
		oula, radius, ulna, clavicle, scapula (othe ormity, including any of the following (	r than acromion), rib, tarsus or carpus, for if performed):
	(a) removal of be	one;	
	(b) excision of su	urrounding osteophytes;	
	(c) synovectomy	;	
	(d) joint release;		
Amend Fee	—one bone (H)	(Anaes.) (Assist.)	
48406	Fee: \$342.90	<b>Benefit:</b> 75% = \$257.20	
		oula, radius, ulna, clavicle, scapula (othe ormity, with internal fixation, including	r than acromion), rib, tarsus or carpus, for any of the following (if performed):
	(a) removal of be	one;	
	(b) excision of su	urrounding osteophytes;	
	(c) synovectomy	;	
	(d) joint release;		
Amend	—one bone (H)	(Anaes.) (Assist.)	
<b>Fee</b> 48409	Fee: \$538.80	<b>Benefit:</b> 75% = \$404.10	
Amend	Osteotomy of hu	merus, without internal fixation (H) (Ar	naes.) (Assist.)
Fee 48412	Fee: \$656.20	<b>Benefit:</b> 75% = \$492.15	
Amend Fee	Osteotomy of hu	merus, with internal fixation (H) (Anaes	s.) (Assist.)
48415	Fee: \$832.65	<b>Benefit:</b> 75% = \$624.50	
	Osteotomy of dis of the following	•	thout internal or external fixation, including any
	(a) excision of su	irrounding osteophytes;	
<b>New</b> 48419	(b) release of join	nt;	

T8. SUR	GICAL OPERATI	ONS 15. ORTHOPAE	DIC
	(c) removal of bo	ne;	
	(d) synovectomy;		
	—one bone (H) (.	Anaes.) (Assist.)	
	Fee: \$656.20	<b>Benefit:</b> 75% = \$492.15	
		al tibia, for correction of deformity, with internal or external fixation by any method he following (if performed):	d,
	(a) excision of su	rounding osteophytes;	
	(b) release of join	t;	
	(c) removal of bo	ne;	
	(d) synovectomy;		
	—one bone (H) (	Anaes.) (Assist.)	
<b>New</b> 48420	Fee: \$832.65	<b>Benefit:</b> 75% = \$624.50	
Amend		ximal tibia, to alter lower limb alignment or rotation (or both), with internal or exter (H) (Anaes.) (Assist.)	rnal
<b>Fee</b> 48421	Fee: \$956.30	<b>Benefit:</b> 75% = \$717.25	
		al femur, to alter lower limb alignment or rotation (or both), with internal or externa (H) (Anaes.) (Assist.)	al
<b>New</b> 48422	Fee: \$950.25	<b>Benefit:</b> 75% = \$712.70	
	Osteotomy of pel	vis, in a patient aged 18 years or over, including any of the following (if performed)	):
	(a) associated intr	a-articular procedures;	
	(b) bone grafting;		
	(c) internal fixation	n	
	(H) (Anaes.) (Ass	ist.)	
<b>New</b> 48423	Fee: \$783.80	<b>Benefit:</b> 75% = \$587.85	
		vis, in a patient aged less than 18 years, with application of hip spica, including inte med), other than a service to which item 48245, 48248, 48251, 48254 or 48257 app ist.)	
<b>Amend</b> <b>Fee</b> 48424	(See para TN.8.127 <b>Fee:</b> \$783.80	of explanatory notes to this Category) Benefit: 75% = \$587.85	
	Osteotomy of fen performed):	nur, in a patient aged 18 years or over, including either or both of the following (if	
	(a) bone grafting;		
<b>New</b> 48426	(b) internal fixation	n	

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDIC				
	(H) (Anaes.) (Assist.)				
	<b>Fee:</b> \$950.25 <b>Benefit:</b> 75% = \$712.70				
Amend Fee	Osteotomy of femur, in a patient aged less than 18 years, including internal fixation (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)				
<b>гее</b> 48427	<b>Fee:</b> \$950.25 <b>Benefit:</b> 75% = \$712.70				
	Excision of one or more osteophytes of the foot or ankle, or simple removal of bunion, including any of the following (if performed):				
	(a) capsulotomy;				
	(b) excision of surrounding osteophytes;				
	(c) release of ligaments;				
	(d) removal of one or more associated bursae or ganglia;				
	(e) removal of bone;				
	(f) synovectomy;				
	—each incision (H) (Anaes.) (Assist.)				
<b>New</b> 48430	<b>Fee:</b> \$279.20 <b>Benefit:</b> 75% = \$209.40				
	Treatment of non-union or malunion, with preservation of the joint, for ankle or hindfoot fracture, with internal or external fixation by any method, including any of the following (if performed):				
	(a) arthrotomy;				
	(b) debridement;				
	(c) excision of surrounding osteophytes;				
	(d) osteotomy;				
	(e) release of joint;				
	(f) removal of bone;				
	(g) removal of hardware;				
	(h) synovectomy;				
	—one bone (H) (Anaes.) (Assist.)				
<b>New</b> 48433	<b>Fee:</b> \$1,111.90 <b>Benefit:</b> 75% = \$833.95				
	Treatment of non-union or malunion, with preservation of the joint, for midfoot or forefoot fracture, with internal or external fixation by any method, including any of the following (if performed):				
	(a) arthrotomy;				
<b>New</b> 48435	(b) debridement;				

T8. SUR	GICAL OPERATI	ONS 15. ORTHOPAEDIC	
	(c) excision of su	rrounding osteophytes;	
	(d) osteotomy;		
	(e) release of join	ıt;	
	(f) removal of bo	ne;	
	(g) removal of ha	rdware;	
	(h) synovectomy	;	
	—one bone (H)		
	(Anaes.) (Assist	.)	
	Fee: \$587.75	<b>Benefit:</b> 75% = \$440.85	
		istillation of greater trochanter, with internal fixation (H) (Anaes.) (Assist.)	
<b>New</b> 50395	<b>Fee:</b> \$950.25	<b>Benefit:</b> 75% = \$712.70	
00070		EPIPHYSEODESIS	
	Epiphysiodesis o	f a long bone, in a patient less than 18 years of age (H) (Anaes.) (Assist.)	
<b>New</b> 48507	<b>Fee:</b> \$381.05	<b>Benefit:</b> 75% = \$285.80	
40307		esis, partial growth plate arrest using internal fixation, in a patient less than 18 years of	
Amend	age (H) (Anaes.)		
<b>Fee</b> 48509	Fee: \$342.90	<b>Benefit:</b> 75% = \$257.20	
Amend Fee	Epiphysiolysis, re (Assist.)	elease of focal growth plate closure, in a patient less than 18 years of age (H) (Anaes.)	
48512	Fee: \$930.65	<b>Benefit:</b> 75% = \$698.00	
		SHOULDER	
Amend Fee	Shoulder, excisio (Anaes.) (Assist.)	n of coraco-acromial ligament or removal of calcium deposit from cuff or both	
48900	Fee: \$293.75	<b>Benefit:</b> 75% = \$220.35 85% = \$249.70	
Amend	Shoulder, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (H) (Anaes.) (Assist.)		
Fee 48903	Fee: \$587.75	<b>Benefit:</b> 75% = \$440.85	
Amend Fee	Shoulder, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both—other than a service associated with a service to which item 48900 applies (H) (Anaes.) (Assist.)		
гее 48906	Fee: \$587.75	<b>Benefit:</b> 75% = \$440.85	
Amend	excision of corac	of rotator cuff, including decompression of subacromial space by acromioplasty, o-acromial ligament and distal clavicle, or any combination, other than a service service to which item 48903 applies (H) (Anaes.) (Assist.)	
<b>Fee</b> 48909	Fee: \$783.80	<b>Benefit:</b> 75% = \$587.85	
	1		

T8. SUR	GICAL OPERATIO	NS 15. ORTHOPAEDIO
Amend	Shoulder, hemi-arth	roplasty of (H) (Anaes.) (Assist.)
Fee 48915	Fee: \$783.80	<b>Benefit:</b> 75% = \$587.85
	Anatomic or reverse	total shoulder replacement, including any of the following (if performed):
	(a) associated rotate	r cuff repair;
	(b) biceps tenodesis	;
	(c) tuberosity osteo	omy;
Amend	service described in	associated with a service to which another item in this Schedule applies if the the other item is for the purpose of performing a procedure on the shoulder region opic means (H) (Anaes.) (Assist.)
Fee 48918	Fee: \$1,567.50	<b>Benefit:</b> 75% = \$1175.65
Amend	Shoulder, total repla	cement arthroplasty, revision of (H) (Anaes.) (Assist.)
Fee 48921	Fee: \$1,616.30	<b>Benefit:</b> 75% = \$1212.25
	Revision of total sh	oulder replacement, including either or both of the following (if performed):
	(a) bone graft to hu	nerus;
	(b) bone graft to sca	pula
Amend Fee	(H) (Anaes.) (Assis	.)
48924	Fee: \$1,861.30	<b>Benefit:</b> 75% = \$1396.00
Amend Fee	Shoulder prosthesis	removal of (H) (Anaes.) (Assist.)
48927	Fee: \$381.90	<b>Benefit:</b> 75% = \$286.45
Amend Fee	Shoulder, arthrodes	s of, with synovectomy if performed (H) (Anaes.) (Assist.)
48939	Fee: \$1,126.55	<b>Benefit:</b> 75% = \$844.95
	Arthrodesis of shou (if performed):	lder, with bone grafting or internal fixation, including either or both of the following
	(a) removal of prost	hesis;
	(b) synovectomy;	
Amend Fee	other than a service applies (H) (Anaes.	associated with a service to which item 48245, 48248, 48251, 48254 or 48257 (Assist.)
48942	Fee: \$1,469.40	<b>Benefit:</b> 75% = \$1102.05
Amend	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	
<b>Fee</b> 48945	Fee: \$284.00	<b>Benefit:</b> 75% = \$213.00
<b>Amend</b> <b>Fee</b> 48948	decompression of c	oscopic surgery of, involving any 1 or more of: removal of loose bodies; alcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - associated with any other arthroscopic procedure of the shoulder region (H) (Anaes.)

T8. SUR	GICAL OPERAT	IONS 15. ORTHOPAEDIC	
	(Assist.)		
	Fee: \$636.75	<b>Benefit:</b> 75% = \$477.60	
Amend Fee		throscopic division of coraco-acromial ligament including acromioplasty - not being a ed with any other arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	
48951	Fee: \$930.65	<b>Benefit:</b> 75% = \$698.00	
Amend Fee	performed), othe if the service des	shoulder, performed as an independent procedure, including release of contracture (if er than a service associated with a service to which another item in this Schedule applies scribed in the other item is for the purpose of performing a procedure on the shoulder scopic means (H) (Anaes.) (Assist.)	
48954	Fee: \$979.60	<b>Benefit:</b> 75% = \$734.70	
New	open or arthrosco grafting and rem this Schedule app	n procedure for multi-directional instability of shoulder, anterior or posterior repair, by opic means, including labral repair or attachment (if performed), excluding bone loval of hardware, other than a service associated with a service to which another item in plies if the service described in the other item is for the purpose of performing a e shoulder region by arthroscopic means (H) (Anaes.) (Assist.)	
48958	Fee: \$1,126.55	<b>Benefit:</b> 75% = \$844.95	
Amend Fee	assisted or mini of separate approac shoulder region (	construction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by the when performed - not being a service associated with any other procedure of the (H) (Anaes.) (Assist.)	
48960	Fee: \$979.60	<b>Benefit:</b> 75% = \$734.70	
<b>New</b> 48972	Tenodesis of bic (Anaes.) (Assist. <b>Fee:</b> \$450.50	Benefit: 75% = \$337.90	
New		rotopic ossification, myositis ossificans or post-traumatic ossification in the shoulder	
48980	Fee: \$832.65	<b>Benefit:</b> 75% = \$624.50	
		ELBOW	
NT	Excision of heter (Anaes.) (Assist.	rotopic ossification, myositis ossificans or post-traumatic ossification in the elbow (H)	
<b>New</b> 48983	Fee: \$610.65	<b>Benefit:</b> 75% = \$458.00	
	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the forearm (H) (Anaes.) (Assist.)		
<b>New</b> 48986	Fee: \$832.65	<b>Benefit:</b> 75% = \$624.50	
Amend Fee	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (H) (Anaes.) (Assist.)		
	Fee: \$342.90	<b>Benefit:</b> 75% = \$257.20	
49100	1001 \$5 12.90		
		more ligaments of the elbow, for acute instability—within 6 weeks after the time of es.) (Assist.)	

T8. SUR	GICAL OPERATI	ONS	15. ORTHOPAEDIC		
		he or more ligaments of the elbow, for chronic is weeks or more after the time of injury (H) (Anae			
<b>New</b> 49105	Fee: \$808.15	<b>Benefit:</b> 75% = \$606.15			
_	ELBOW, arthrod	esis of, with synovectomy if performed (Anaes.	) (Assist.)		
Fee 49106	Fee: \$979.60	<b>Benefit:</b> 75% = \$734.70 85% = \$894.90			
Amend Fee	ELBOW, total sy	ELBOW, total synovectomy of (H) (Anaes.) (Assist.)			
49109	Fee: \$734.65	<b>Benefit:</b> 75% = \$551.00			
Amend Fee	Radial head repla applies (H) (Anac	cement of elbow, other than a service associated es.) (Assist.)	d with a service to which item 49115		
49112	Fee: \$734.65	<b>Benefit:</b> 75% = \$551.00			
Amend Fee	stabilisation proc (Anaes.) (Assist.)				
49115	Fee: \$1,175.40	<b>Benefit:</b> 75% = \$881.55			
Amend Fee	ELBOW, total rej (Anaes.) (Assist.)	placement arthroplasty of, revision procedure, in	ncluding removal of prosthesis (H)		
49116	Fee: \$1,551.55	<b>Benefit:</b> 75% = \$1163.70			
Amend Fee	Revision of total (H) (Anaes.) (Ass	replacement arthroplasty of elbow, including bo ist.)	one grafting and removal of prosthesis		
49117	Fee: \$1,861.85	<b>Benefit:</b> 75% = \$1396.40			
Amend Fee		tic arthroscopy of, including biopsy and lavage, procedure of the elbow (H) (Anaes.) (Assist.)	, not being a service associated with any		
49118	Fee: \$284.00	<b>Benefit:</b> 75% = \$213.00			
	Surgery of the ell	ow, by arthroscopic means, including any of the	e following (if performed):		
	(a) chondroplasty	;			
	(b) drilling of defect;				
	(c) osteoplasty;				
	(d) removal of lo	ose bodies;			
	(e) release of con	tracture or adhesions;			
	(f) treatment of epicondylitis;				
Amend Fee		ce associated with a service to which another ite in the other item is for the purpose of an arthros	11		
49121	Fee: \$636.75	<b>Benefit:</b> 75% = \$477.60			
<b>New</b> 49124		anon bursa, including bony prominence, other th item in this Schedule applies if the service descr			

T8. SUR	GICAL OPERAT	IONS		15. ORTHOPAEDIC	
	of an arthroscopi	ic procedure of the elbow (	Anaes.) (Assist.)		
	Fee: \$386.55	<b>Benefit:</b> 75% = \$289.9	5 85% = \$328.60		
			WRIST		
		is of, with synovectomy if point (H) (Anaes.) (Assist.)	performed, with or wit	hout bone graft and internal fixation of	
<b>Amend</b> <b>Fee</b> 49200	(See para TN.8.11) <b>Fee:</b> \$852.15	6 of explanatory notes to this <b>Benefit:</b> 75% = \$639.1			
	Limited fusion o	of wrist, with or without bo	ne graft, including eac	h of the following:	
	(a) ligament or te	endon transfers;			
	(b) partial or tota	al excision of one or more of	carpal bones;		
	(c) rebalancing p	procedures;			
	(d) synovectomy	7			
	(H) (Anaes.) (As	ssist.)			
Amend Fee 49203	(See para TN.8.116 of explanatory notes to this Category) <b>Fee:</b> \$807.20 <b>Benefit:</b> 75% = \$605.40				
	Proximal row ca	rpectomy of wrist, includir	ng either or both of the	following (if performed):	
	(a) styloidectom	у;			
	(b) synovectomy	7			
	(H) (Anaes.) (As	ssist.)			
<b>Amend</b> <b>Fee</b> 49206	(See para TN.8.11 <b>Fee:</b> \$587.75	6 of explanatory notes to this <b>Benefit:</b> 75% = \$440.8			
	Prosthetic replac performed):	ement of wrist or distal rac	lioulnar joint, includin	g either or both of the following (if	
	(a) ligament real	ignment;			
	(b) tendon realig	nment			
	(H) (Anaes.) (Assist.)				
Amend Fee 49209	(See para TN.8.11 <b>Fee:</b> \$783.80	6 of explanatory notes to this <b>Benefit:</b> 75% = \$587.8			
	Revision of total following (if per		of wrist or distal radiou	Inar joint, including any of the	
	(a) ligament reba	alancing;			
	(b) removal of pr	rosthesis;			
	(c) tendon rebalancing				
<b>Amend</b> <b>Fee</b> 49210	(H) (Anaes.) (As	ssist.)			

T8. SUR	GICAL OPERATIO	NS	15. ORTHOPAEDIC	
	Fee: \$1,034.60	<b>Benefit:</b> 75% = \$775.95		
	Arthrotomy of wris performed):	t or distal radioulnar joint, for infection, i	ncluding any of the following (if	
	(a) joint debrideme	nt;		
	(b) removal of loos	e bodies;		
	(c) synovectomy			
Amend	(H) (Anaes.) (Assis	t.)		
<b>Fee</b> 49212	(See para TN.8.116 o <b>Fee:</b> \$245.05	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$183.80		
	Sauve-Kapandji pro	ocedure of distal radioulnar joint, includir	ng any of the following (if performed):	
	a) radioulnar fusion	;		
	b) osteotomy;			
	c) soft tissue reconstruction			
	(Anaes.) (Assist.)			
New 49213	Fee: \$876.65	<b>Benefit:</b> 75% = \$657.50 85% = \$791.95		
	Reconstruction of s the following (if pe		f wrist, by open procedure, including any of	
	(a) arthrotomy;			
	(b) ligament harvesting and grafting;			
	(c) synovectomy;			
	(d) tendon harvestin	ng and grafting;		
	(e) insertion of synt	hetic ligament substitute		
Amend	(H) (Anaes.) (Assis	t.)		
<b>Fee</b> 49215	(See para TN.8.116 o <b>Fee:</b> \$676.05	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$507.05		
		throscopy of, including radiocarpal or mi associated with another arthroscopic pro	dcarpal joints, or both (including biopsy)— cedure of the wrist joint (H) (Anaes.)	
Amend Fee 49218	(See para TN.8.116 o <b>Fee:</b> \$284.00	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$213.00		
		netacarpal of thumb or joint of digit, by a	arthroscopic means, including biopsy (if	
<b>New</b> 49219	<b>Fee:</b> \$284.00	<b>Benefit:</b> 75% = \$213.00		
<b>New</b> 49220	Treatment of carpo	metacarpal of thumb or joint of digit, by a	arthroscopic means—one joint (H) (Anaes.)	

T8. SUR	GICAL OPERATIO	NS	15. ORTHOPAEDI
	(Assist.)		
	Fee: \$636.75	<b>Benefit:</b> 75% = \$477.60	
	Treatment of wrist,	by arthroscopic means, including any of the f	following (if performed):
	(a) drilling of defect	t.	
	(b) removal of loose	e bodies;	
	(c) release of adhesions;		
	(d) synovectomy;		
	(e) debridement;		
	(f) resection of dors	al or volar ganglia;	
	other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.)		
<b>Amend</b> F <b>ee</b> 49221	(See para TN.8.116 of <b>Fee:</b> \$636.75	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$477.60	
	Osteoplasty of wrist	t, by arthroscopic means, including either or b	both of the following (if performed):
	(a) excision of the distal ulna;		
	(b) total synovectomy;		
	other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint—2 or more distinct areas (H) (Anaes.) (Assist.)		
<b>Amend</b> F <b>ee</b> 19224	(See para TN.8.116 of <b>Fee:</b> \$734.65	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$551.00	
	Treatment of wrist b	by one of the following:	
	(a) pinning of osteo	chondral fragment, by arthroscopic means;	
	(b) stabilisation pro-	cedure for ligamentous disruption;	
	(c) partial wrist fusi	on or carpectomy, by arthroscopic means;	
	(d) fracture manage	ment;	
	other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.)		
<b>Amend</b> F <b>ee</b> 19227	(See para TN.8.116 of <b>Fee:</b> \$734.65	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$551.00	
<b>New</b> 49230	Total, hemi or interp including all of the	positional prosthetic replacement of carpal bo following:	one of wrist, for trauma or emergency,

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDIC
	(a) ligament and tendon rebalancing procedures;
	(b) limited wrist fusions;
	(c) limited bone grafting
	(H) (Anaes.) (Assist.)
	<b>Fee:</b> \$958.55 <b>Benefit:</b> 75% = \$718.95
	Excisional arthroplasty of single (or part of) carpal bone of wrist, when transfers of ligaments or tendons, or rebalancing procedures, are not required, including all of the following:
	(a) radial styloidectomy;
	(b) ulnar styloidectomy;
	(c) proximal hamate;
	(d) partial scaphoid;
	other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a distal radial ulnar joint reconstruction, a proximal row carpectomy or another wrist procedure—applicable once for a single operation (H) (Anaes.) (Assist.)
<b>New</b> 49233	<b>Fee:</b> \$403.60 <b>Benefit:</b> 75% = \$302.70
	Stabilisation of soft tissue of distal radioulnar joint, by open procedure, with or without ligament or tendon grafting, including either or both of the following (if performed):
	(a) graft harvest;
	(b) triangular fibrocartilage complex repair or reconstruction
	(H) (Anaes.) (Assist.)
<b>New</b> 49236	<b>Fee:</b> \$608.45 <b>Benefit:</b> 75% = \$456.35
<b>.</b>	Excision of pisiform or hook of hamate, including release of ulnar nerve (if performed) (H) (Anaes.) (Assist.)
<b>New</b> 49239	Fee: \$302.70 Benefit: 75% = \$227.05
	HIP
	Combined anterior and posterior pelvic ring disruption, including sacroiliac joint disruption, treatment of fracture by open reduction and internal fixation of both anterior and posterior ring segments
<b>N</b> .T	(H) (Anaes.) (Assist.)
<b>New</b> 47491 S	<b>Fee:</b> \$1,616.32 <b>Benefit:</b> 75% = \$1212.25
Amend Fee	Sacro-iliac joint—arthrodesis of (H) (Anaes.) (Assist.)
49300	<b>Fee:</b> \$542.40 <b>Benefit:</b> 75% = \$406.80
	Arthrotomy of hip, by open procedure, including any of the following (if performed):
<b>Amend</b> <b>Fee</b> 49303	(a) lavage;

T8. SUR	GICAL OPERATION	ONS	15. ORTHOPAEDIC
	(b) drainage;		
	(c) biopsy		
	(H) (Anaes.) (Ass	ist.)	
	(See para TN.8.127 <b>Fee:</b> \$568.10	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$426.10	
Amend	Hip, arthrodesis o	f, with synovectomy if performed (H) (Anaes.)	(Assist.)
<b>Fee</b> 49306	Fee: \$1,126.55	<b>Benefit:</b> 75% = \$844.95	
	Arthrectomy or ex	ccision arthroplasty (Girdlestone) of hip, other t	han a service performed:
	(a) for the purpose	e of implant removal; or	
	(b) as stage 1 of a	2-stage procedure	
Amend	(H) (Anaes.) (Ass	ist.)	
<b>Fee</b> 49309	Fee: \$783.80	<b>Benefit:</b> 75% = \$587.85	
Amend	Hip, arthroplasty	of, unipolar or bipolar (H) (Anaes.) (Assist.)	
<b>Fee</b> 49315	Fee: \$881.65	<b>Benefit:</b> 75% = \$661.25	
Amend	Total arthroplasty of hip, including minor bone grafting (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)		
<b>Fee</b> 49318	Fee: \$1,371.25	<b>Benefit:</b> 75% = \$1028.45	
Amend Fee	Bilateral total arthroplasty of hip, including minor bone grafting (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)		
49319	Fee: \$2,409.15	<b>Benefit:</b> 75% = \$1806.90	
	Total arthroplasty	of hip, with internal fixation, including either of	or both of the following (if performed):
	(a) structural bone graft;		
	(b) insertion of synthetic substitutes or metal augments;		
Amend	other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 482 applies (H) (Anaes.) (Assist.)		5, 48248, 48251, 48254 or 48257
<b>Fee</b> 49321	Fee: \$1,665.50	<b>Benefit:</b> 75% = \$1249.15	
Amend Fee	Diagnostic arthroscopy of hip, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure of the hip joint by arthroscopic means (H) (Anaes.) (Assist.)		for the purpose of performing a
49360	Fee: \$357.90	<b>Benefit:</b> 75% = \$268.45	
<b>Amend</b> <b>Fee</b> 49363	soft tissue in the s	by arthroscopic means, with synovial biopsy, in ame area (if performed), other than a service as is Schedule applies if the service described in th	sociated with a service to which

T8. SUR	GICAL OPERATIC	NS 15. ORTHOPAEDIC	
	(a) a procedure of	he hip joint by arthroscopic means; or	
	(b) surgery for fem	oroacetabular impingement	
	(H) (Anaes.) (Assis	st.)	
	Fee: \$431.00	<b>Benefit:</b> 75% = \$323.25	
	same area (if perfo	y arthroscopic means, including any procedures to treat bone or soft tissue in the rmed), other than a service associated with a service to which another item in this the service described in the other item is for the purpose of performing:	
	(a) a procedure of	he hip joint by arthroscopic means; or	
	(b) surgery for fem	oroacetabular impingement	
	(H) (Anaes.) (Assis	st.)	
<b>Amend</b> <b>Fee</b> 49366	(See para TN.8.127 o <b>Fee:</b> \$636.75	of explanatory notes to this Category) Benefit: 75% = \$477.60	
<b>N</b> .	Revision arthroplas	sty of hip, with exchange of head or liner (or both) (H) (Anaes.) (Assist.)	
<b>New</b> 49372	Fee: \$959.80	<b>Benefit:</b> 75% = \$719.85	
<b>N</b> .T	-	sty of hip, with exchange of head and acetabular shell or cup, including minor bone hed) (H) (Anaes.) (Assist.)	
<b>New</b> 49374	Fee: \$1,782.55	<b>Benefit:</b> 75% = \$1336.95	
	Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including major bone grafting (if performed) (H) (Anaes.) (Assist.)		
<b>New</b> 49376	Fee: \$2,193.95	<b>Benefit:</b> 75% = \$1645.50	
	Revision arthroplasty of hip, with revision of femoral component (if there is no requirement for femoral osteotomy), including minor bone grafting (if performed) (H) (Anaes.) (Assist.)		
<b>New</b> 49378	Fee: \$1,919.60	<b>Benefit:</b> 75% = \$1439.70	
	Revision arthroplasty of hip, with revision of femoral and acetabular components (if femoral osteotomy is not required), including minor bone grafting (if performed) (H) (Anaes.) (Assist.)		
<b>New</b> 49380	Fee: \$2,331.05	<b>Benefit:</b> 75% = \$1748.30	
	Revision arthroplasty of hip, with revision of femoral and acetabular components (if femoral osteotomy is not required), including major bone grafting (H) (Anaes.) (Assist.)		
<b>New</b> 49382	Fee: \$3,016.65	<b>Benefit:</b> 75% = \$2262.50	
N	Revision arthroplasty of hip, for pelvic discontinuity, with revision of acetabular component (H) (Anaes.) (Assist.)		
<b>New</b> 49384	Fee: \$3,565.10	<b>Benefit:</b> 75% = \$2673.85	
		sty of hip, with revision of femoral component with femoral osteotomy, including g (if performed) (H) (Anaes.) (Assist.)	
<b>New</b> 49386	Fee: \$2,468.15	<b>Benefit:</b> 75% = \$1851.15	
<b>New</b> 49388	Revision arthroplas	sty of hip, including:	

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC		
	(a) revision of both of the following:			
	(i) femoral component with femoral osteotomy;			
	(ii) acetabular component; and			
	(b) minor bone grafting (if performed)			
	(H) (Anaes.) (Assist.)			
	<b>Fee:</b> \$2,879.60 <b>Benefit:</b> 75% = \$2159.70			
	Revision arthroplasty of hip, including:			
	(a) revision of both of the following:			
	(i) femoral component with femoral osteotomy;			
	(ii) acetabular component; and			
	(b) major bone grafting			
	(H) (Anaes.) (Assist.)			
<b>New</b> 49390	<b>Fee:</b> \$3,428.00 <b>Benefit:</b> 75% = \$2571.00			
	Revision arthroplasty of hip, including:			
	(a) either:			
	(i) revision of femoral component with femoral osteotomy; or			
	(ii) proximal femoral replacement; and			
	(b) revision of acetabular component for pelvic discontinuity			
	(H) (Anaes.) (Assist.)			
<b>New</b> 49392	<b>Fee:</b> \$4,799.20 <b>Benefit:</b> 75% = \$3599.40			
	Revision arthroplasty of hip, including:			
	(a) replacement of proximal femur; and			
	(b) revision of the acetabular component; and			
	(c) bone grafting (if performed)			
<b>New</b> 49394	(H) (Anaes.) (Assist.)			
	<b>Fee:</b> \$4,113.60 <b>Benefit:</b> 75% = \$3085.20			
	Revision arthroplasty of hip, including:			
	(a) removal of prosthesis as stage 1 of a 2-stage revision arthroplasty or as a def and	initive stage procedure;		
<b>New</b> 49396	(b) insertion of temporary prosthesis (if performed)			

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDIC		
	(H) (Anaes.) (Assist.)		
	<b>Fee:</b> \$2,742.35 <b>Benefit:</b> 75% = \$2056.80		
	Revision arthroplasty of hip, including:		
	(a) revision of femoral component for periprosthetic fracture; and		
	(b) internal fixation; and		
	(c) bone grafting (if performed)		
	(H) (Anaes.) (Assist.)		
<b>New</b> 49398	<b>Fee:</b> \$2,056.85 <b>Benefit:</b> 75% = \$1542.65		
	Stabilisation of joint of hip, by open means, including any of the following (if performed):		
	(a) repair of capsule;		
	(b) labrum;		
	(c) capsulorraphy;		
	(d) repair of ligament;		
	(e) internal fixation;		
	other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.)		
<b>New</b> 50107	<b>Fee:</b> \$489.75 <b>Benefit:</b> 75% = \$367.35		
	KNEE		
	Repair or reconstruction (or both) of acute traumatic chondral injury to the distal femoral or proximal tibial articular surfaces of the knee, when chondral or osteochondral implants or transfers are utilised (H (Anaes.) (Assist.)		
<b>New</b> 47592	<b>Fee:</b> \$339.20 <b>Benefit:</b> 75% = \$254.40		
Amend	Knee, arthrotomy of, involving one or more of capsular release, biopsy or lavage, or removal of loose body or foreign body (H) (Anaes.) (Assist.)		
Fee 49500	<b>Fee:</b> \$391.80 <b>Benefit:</b> 75% = \$293.85		
	Arthrotomy of knee, including one of the following:		
	(a) meniscal surgery;		
	(b) repair of collateral or cruciate ligament;		
	(c) patellectomy;		
	(d) single transfer of ligament or tendon;		
Amend	(e) repair or replacement of chondral or osteochondral surface (excluding prosthetic replacement);		
<b>Fee</b> 49503	other than a service associated with a service to which another item in this Group applies (H) (Anaes.)		

T8. SUR	GICAL OPERATI	ONS 15. ORTHOPAEDI		
	(Assist.)			
	Fee: \$509.40	<b>Benefit:</b> 75% = \$382.05		
	Arthrotomy of kn	ee, including 2 or more of the following:		
	(a) meniscal surg	ery;		
	(b) repair of colla	teral or cruciate ligament;		
	(c) patellectomy;			
	(d) single transfer	of ligament or tendon;		
	(e) repair or repla	cement of chondral or osteochondral surface (excluding prosthetic replacement);		
Amend Fee	other than a servi (Assist.)	ce associated with a service to which another item in this Group applies (H) (Anaes.)		
49506	Fee: \$764.15	<b>Benefit:</b> 75% = \$573.15		
Amend	service to which	y of knee, by open procedure, other than a service performed in association with a nother item in this Schedule applies if the service described in the other item is for the ning an arthroplasty (H) (Anaes.) (Assist.)		
<b>Fee</b> 49509	Fee: \$783.80	<b>Benefit:</b> 75% = \$587.85		
Amend Fee	Primary or revision	n arthrodesis of knee, including arthrodesis (H) (Anaes.) (Assist.)		
49512	Fee: \$1,371.25	<b>Benefit:</b> 75% = \$1028.45		
	Removal of cemented or uncemented knee prosthesis, performed as the first stage of a 2-stage procedure; including:			
	(a) removal of as	(a) removal of associated cement; and		
	(b) insertion of spacer (if required)			
Amend	(H) (Anaes.) (Assist.)			
Fee 49515	Fee: \$881.65	<b>Benefit:</b> 75% = \$661.25		
	Bilateral unicom	artmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.)		
<b>New</b> 49516	Fee: \$2,196.65	<b>Benefit:</b> 75% = \$1647.50		
Amend	Unicompartment	l arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.)		
<b>Fee</b> 49517	Fee: \$1,255.25	<b>Benefit:</b> 75% = \$941.45		
	Total replacemen	arthroplasty of knee, including either or both of the following (if performed):		
	(a) revision of patello-femoral joint replacement to total knee replacement;			
	(b) patellar resurfacing;			
A	other than a servi applies (H) (Anae	ce associated with a service to which item 48245, 48248, 48251, 48254 or 48257 s.) (Assist.)		
Amend Fee				

RGICAL OPERATIONS 15. ORTHO	PAEDIC	
<b>Fee:</b> \$2,409.15 <b>Benefit:</b> 75% = \$1806.90		
Complex primary arthroplasty of knee, with revision of components to femur or tibia, including both of the following (if performed):	either or	
(a) ligament reconstruction;		
(b) patellar resurfacing;		
other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 4823 applies (H) (Anaes.) (Assist.)	57	
<b>Fee:</b> \$1,665.50 <b>Benefit:</b> 75% = \$1249.15		
Complex primary arthroplasty of knee, with revision of components to femur and tibia, includin or both of the following (if performed):	g either	
(a) ligament reconstruction;		
(b) patellar resurfacing;		
other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 4823 applies (H) (Anaes.) (Assist.)	57	
<b>Fee:</b> \$1,959.30 <b>Benefit:</b> 75% = \$1469.50		
Revision of uni-compartmental arthroplasty of the knee, with femoral or tibial components (or b with uni-compartmental implants, other than a service associated with a service to which:	oth)	
(a) item 48245, 48248, 48251, 48254 or 48257 applies; or		
(b) another item in this Group applies if the service described in the other item is for the purpose performing surgery on a knee (H) (Anaes.) (Assist.)	e of	
<b>Fee:</b> \$1,665.50 <b>Benefit:</b> 75% = \$1249.15		
Minor revision of total or partial replacement of knee, including either or both of the following:		
(a) exchange of polyethylene component (including uni);		
(b) insertion of patellar component;		
other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)		
<b>Fee:</b> \$1,371.25 <b>Benefit:</b> 75% = \$1028.45		
Revision of total or partial replacement of knee, with exchange of femoral or tibial component:		
(a) excluding revision of unicompartmental with unicompartmental implants; and		
(b) including patellar resurfacing (if performed);		
other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 4825	57	
	Bilateral total replacement arthroplasty of knee, including patellar resurfacing, other than a servi associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anac (Assist.)         Fee: \$2,409,15       Benefit: 75% = \$1806.90         Complex primary arthroplasty of knee, with revision of components to femur or tibia, including both of the following (if performed): <ul> <li>(a) ligament reconstruction;</li> <li>(b) patellar resurfacing;</li> <li>other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 482; applies (H) (Anaes.) (Assist.)</li> </ul> Fee: \$1,665.50         Benefit: 75% = \$1249.15           Complex primary arthroplasty of knee, with revision of components to femur and tibia, includin or both of the following (if performed): <ul> <li>(a) ligament reconstruction;</li> <li>(b) patellar resurfacing;</li> <li>other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 482; applies (H) (Anaes.) (Assist.)</li> </ul> Fee: \$1,959.30         Benefit: 75% = \$1469.50           Revision of uni-compartmental arthroplasty of the knee, with femoral or tibial components (or b with uni-compartmental implants, other than a service associated with a service to which: <ul> <li>(a) another item in this Group applies if the service described in the other item is for the purpose performing surgery on a knee (H) (Anaes.) (Assist.)</li> </ul> Fee: \$1,665.50         Benefit: 75% = \$1249.15           Minor revision of total or partial replacement of knee, including either or both of t	

T8. SUR	GICAL OPERATI	ONS 15. ORTHO	PAEDIC	
	applies (H) (Anae	es.) (Assist.)		
	Fee: \$2,057.35	<b>Benefit:</b> 75% = \$1543.05		
Amend Fee	Revision of total or partial replacement of knee, with exchange of femoral and tibial components, excluding revision of unicompartmental with unicompartmental implants, including patellar resurfacing (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)		urfacing	
49533	Fee: \$2,645.55	<b>Benefit:</b> 75% = \$1984.20		
Amend Fee	Replacement of p (H) (Anaes.) (Ass	batella and trochlea of patello-femoral joint of knee, performed as a primary prosist.)	ocedure	
49534	Fee: \$756.75	<b>Benefit:</b> 75% = \$567.60		
	Either:			
	(a) repair of cruci	ate ligaments of knee; or		
	(b) repair or recor	nstruction of collateral ligaments of knee;		
	by open or arthro	scopic means, including either or both of the following (if performed):		
	(c) graft harvest;			
	(d) intraarticular l	knee surgery;		
Amend	service described	ce associated with a service to which another item of this Schedule applies if th in the other item is for the purpose of performing a procedure on the knee by ns (H) (Anaes.) (Assist.)	10	
Fee 49536	Fee: \$979.60	<b>Benefit:</b> 75% = \$734.70		
		f anterior or posterior cruciate ligament of knee, by open or arthroscopic means the following (if performed):	;,	
	(a) graft harvest;			
	(b) donor site repa	(b) donor site repair;		
	(c) meniscal repair;			
	(d) collateral ligat	(d) collateral ligament repair;		
	(e) extra-articular tenodesis;			
	(f) any other associated intra-articular surgery;			
Amend	other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)		ıe	
Fee 49542	Fee: \$1,371.25	<b>Benefit:</b> 75% = \$1028.45		
<b>New</b> 49544		f 2 or more cruciate or collateral ligaments of knee, by open or arthroscopic me the following (if performed):	ans,	

T8. SUR	RGICAL OPERATIONS 15. ORTHOPAEDI		
	(a) ligament repair;		
	(b) graft harvest donor site repair;		
	(c) meniscal repair;		
	(d) any other associated intra-articular surgery;		
	other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)		
	<b>Fee:</b> \$1,596.45 <b>Benefit:</b> 75% = \$1197.35		
Amend	Knee, revision of patello-femoral stabilisation (H) (Anaes.) (Assist.)		
Fee 49548	<b>Fee:</b> \$979.60 <b>Benefit:</b> 75% = \$734.70		
Amend	Knee, revision of procedures to which item 49536 or 49542 applies (H) (Anaes.) (Assist.)		
<b>Fee</b> 49551	<b>Fee:</b> \$1,371.25 <b>Benefit:</b> 75% = \$1028.45		
Amend	Revision of total replacement of knee, by anatomic specific allograft of tibia or femur, other than a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)		
<b>Fee</b> 49554	<b>Fee:</b> \$1,959.30 <b>Benefit:</b> 75% = \$1469.50		
	Stabilisation of patellofemoral joint of knee, by combined open and arthroscopic means, including either or both of the following (if performed):		
	(a) medial soft tissue reconstruction and tendon transfer;		
	(b) tibial tuberosity transfer with bone graft and internal fixation;		
Amend	other than a service associated a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)		
<b>Fee</b> 49564	<b>Fee:</b> \$956.30 <b>Benefit:</b> 75% = \$717.25		
.,	Reconstruction of patellofemoral joint of knee, by combined open and arthroscopic means, including:		
	(a) both of the following:		
	(i) medial soft tissue reconstruction;		
	(ii) tibial tuberosity transfer; and		
	(b) any of the following (if performed):		
	(i) bone graft;		
	(ii) internal fixation;		
	(iii) trochleoplasty;		
<b>New</b> 49565	other than a service associated a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)		

T8. SUR	GICAL OPERATIO	NS	15. ORTHOPAEDIC
	Fee: \$1,372.60	<b>Benefit:</b> 75% = \$1029.45	
Amend	Knee, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (H) (Anaes.) (Assist.)		e or tendon release
<b>Fee</b> 49569	Fee: \$783.80	<b>Benefit:</b> 75% = \$587.85	
		by arthroscopic means, when the pre-procedure e following (if performed):	e diagnosis is undetermined, including
	(a) biopsy;		
	(b) lavage		
New	(H) (Anaes.) (Assis	st.)	
49570	Fee: \$284.00	<b>Benefit:</b> 75% = \$213.00	
New	to which another it	ny of knee, by arthroscopic means, for atrauma em of this Schedule applies if the service descri hritis (H) (Anaes.) (Assist.)	
49572	Fee: \$691.15	<b>Benefit:</b> 75% = \$518.40	
	Removal of loose b	odies of knee, by arthroscopic means—one or	more bodies (H) (Anaes.) (Assist.)
<b>New</b> 49574	Fee: \$691.15	<b>Benefit:</b> 75% = \$518.40	
	Repair of chondral performed):	lesion of knee, by arthroscopic means, includin	ng either or both of the following (if
	(a) microfracture;		
	(b) microdrilling;		
	applies if the service	e performed in combination with a service to we be described in the other item is for the purpose as (H) (Anaes.) (Assist.)	
<b>New</b> 49576	Fee: \$691.15	<b>Benefit:</b> 75% = \$518.40	
	performed in comb	ue, lateral release or osteoplasty of knee, by arthination with a service to which another item of her item is for the purpose of stabilising the pate	this Schedule applies if the service
<b>New</b> 49578	Fee: \$691.15	<b>Benefit:</b> 75% = \$518.40	
	Partial meniscector	ny of knee, by arthroscopic means, for traumati	ic meniscus tear (H) (Anaes.) (Assist.)
<b>New</b> 49580	Fee: \$691.15	<b>Benefit:</b> 75% = \$518.40	
	Meniscal repair of	knee, by arthroscopic means (H) (Anaes.) (Assi	ist.)
<b>New</b> 49582	Fee: \$807.05	<b>Benefit:</b> 75% = \$605.30	
		ondral or meniscal graft of knee, by arthroscopic	c means (H) (Anaes.) (Assist.)
<b>New</b> 49584	Fee: \$807.05	<b>Benefit:</b> 75% = \$605.30	
<b>New</b> 49586	Synovectomy of kr	nee, by arthroscopic means, for neoplasia or influence item of this Schedule applies if the service	

T8. SUR	RGICAL OPERATIONS 15. ORTHOPAEDIC		
	purpose of treating uncomplicated osteoarthritis (Anaes.) (Assist.)		
	<b>Fee:</b> \$807.05 <b>Benefit:</b> 75% = \$605.30 85% = \$722.35		
	Excision of ganglion, cyst or bursa of knee, by open or arthroscopic means, performed as an independen procedure, other than a service associated with a service to which another item in this Group applies (Anaes.) (Assist.)		
<b>New</b> 49590	<b>Fee:</b> \$386.55 <b>Benefit:</b> 75% = \$289.95 85% = \$328.60		
	ANKLE		
	Surgery of ankle joint, by arthroscopic means, including any of the following (if performed):		
	(a) cartilage treatment;		
	(b) removal of loose bodies;		
	(c) synovectomy;		
	(d) excision of joint osteophytes;		
Amend Fee	other than a service associated with a service to which another item in this Group applies if the service described in the other item is for the purpose of performing a procedure on the ankle by arthroscopic means (H) (Anaes.) (Assist.)		
49703	<b>Fee:</b> \$636.75 <b>Benefit:</b> 75% = \$477.60		
Amend	Arthrotomy of joint of ankle, for infection, including removal of loose bodies and joint debridement, including release of joint contracture (if performed) (H) (Anaes.) (Assist.)		
Fee 49706	<b>Fee:</b> \$342.90 <b>Benefit:</b> 75% = \$257.20		
	Stabilisation of ligament of ankle or subtalar joint (or both), including any of the following (if performed):		
	(a) capsulotomy;		
	(b) joint release;		
	(c) synovectomy;		
	(d) joint debridement;		
Amend Fee	one ligament complex, each incision (H) (Anaes.) (Assist.)		
49709	<b>Fee:</b> \$734.65 <b>Benefit:</b> 75% = \$551.00		
	Arthrodesis of ankle, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed):		
	(a) capsulotomy;		
	(b) joint release;		
	(c) synovectomy;		
<b>Amend</b> <b>Fee</b> 49712	(d) removal of osteophytes at joint		

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDI
	(H) (Anaes.) (Assist.)
	<b>Fee:</b> \$979.60 <b>Benefit:</b> 75% = \$734.70
	Total replacement of ankle, with prosthetic replacement of ankle joint, including any of the following (i performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) removal of osteophytes at joint
Amend Fee	(H) (Anaes.) (Assist.)
49715	Fee: \$1,175.40         Benefit: 75% = \$881.55
	Revision of total ankle replacement:
	(a) including either:
	(i) exchange of tibial or talar components (or both) and plastic inserts; or
	(ii) removal of tibial or talar components (or both) and plastic inserts; and
	(b) including any of the following (if performed):
	(i) insertion of cement spacer for infection;
	(ii) capsulotomy;
	(iii) joint release;
	(iv) neurolysis;
	(v) debridement of cysts;
	(vi) synovectomy;
	(vii) joint debridement
	other than a service associated with a service to which 30023 applies.
Amend	(H) (Anaes.) (Assist.)
<b>Fee</b> 49716	<b>Fee:</b> \$1,551.55 <b>Benefit:</b> 75% = \$1163.70
	Revision of total ankle replacement:
	(a) including either:
	(i) exchange of tibial and talar components; or
	(ii) removal of tibial and talar components and conversion to ankle arthrodesis; and
<b>Amend</b> <b>Fee</b> 49717	(b) including both of the following

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDIC
	(iii) internal or external fixation, by any means;
	(iv) major bone grafting; and
	(c) including any of the following (if performed):
	(i) capsulotomy;
	(ii) joint release;
	(iii) neurolysis;
	(iv) debridement and extensive grafting of cysts;
	(v) synovectomy;
	(vi) joint debridement;
	other than a service associated with a service to which item 30023, 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$1,861.85 <b>Benefit:</b> 75% = \$1396.40
	Primary repair of major tendon of ankle, by any method, including either or both of the following (if performed):
	(a) synovial biopsy;
	(b) synovectomy
Amend	—one tendon (H) (Anaes.) (Assist.)
<b>Fee</b> 49718	<b>Fee:</b> \$391.80 <b>Benefit:</b> 75% = \$293.85
	Reconstruction of major tendon of ankle, by any method, including any of the following (if performed):
	(a) synovial biopsy;
	(b) synovectomy;
	(c) adjacent tendon transfer;
	(d) turn down flaps;
Amend	other than a service associated with a service to which item 49718 applies (H) (Anaes.) (Assist.)
<b>Fee</b> 49724	Fee: \$685.85         Benefit: 75% = \$514.40
	Lengthening of major tendon of ankle, including either or both of the following (if performed):
	(a) synovial biopsy;
	(b) synovectomy
Amend	(H) (Anaes.) (Assist.)
<b>Fee</b> 49727	<b>Fee:</b> \$293.75 <b>Benefit:</b> 75% = \$220.35
Amend Fee	Lengthening of Achilles' tendon, by any method, with gastro-soleus lengthening for the correction of

T8. SUF	GICAL OPERATIONS 15. ORTHOPAEDI
49728	equinous deformity, including either or both of the following (if performed):
	(a) synovial biopsy;
	(b) synovectomy;
	other than a service associated with a service to which item 49727 applies (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$587.60 <b>Benefit:</b> 75% = \$440.70
	Revision of arthrodesis of ankle, by open or arthroscopic means, with internal or external fixation by an method, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) removal of osteophytes at joint;
	(e) removal of hardware;
	(f) neurolysis;
	(g) osteotomy of non-union or malunion;
	other than a service associated with a service to which 30023 applies
	(H) (Anaes.) (Assist.)
<b>New</b> 49740	<b>Fee:</b> \$1,469.50 <b>Benefit:</b> 75% = \$1102.15
	Arthrodesis of extended ankle and hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) removal of osteophytes at joint
	(H) (Anaes.) (Assist.)
<b>New</b> 49742	<b>Fee:</b> \$1,387.20 <b>Benefit:</b> 75% = \$1040.40
	Revision of arthrodesis of extended ankle and hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
<b>New</b> 49744	(d) removal of osteophytes at joint;

	15. ORTHOPAEDIC
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T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	(e) removal of hardware;	
	(f) neurolysis;	
	(g) osteotomy of non-union or malunion;	
	other than a service associated with a service to which 30023 applies	
	(H) (Anaes.) (Assist.)	
	<b>Fee:</b> \$2,080.85 <b>Benefit:</b> 75% = \$1560.65	
	Synovectomy of major tendon of ankle, for extensive synovitis by any method, including (if performed):	luding any of the
	(a) tenolysis;	
	(b) debridement of ligament or tendon (or both);	
	(c) release of ligament or tendon (or both);	
	(d) excision of tubercule or osteophyte;	
	(e) reconstruction of tendon retinaculum;	
	(f) neurolysis;	
	other than a service associated with a service to which item 30023 applies—each in (Assist.)	ncision (H) (Anaes.)
<b>New</b> 49771	<b>Fee:</b> \$386.55 <b>Benefit:</b> 75% = \$289.95	
	Revision of total ankle replacement, including:	
	(a) bone grafting of perioperative cysts to the tibia or talus (or both); and	
	(b) retention of implants; and	
	(c) any of the following (if performed):	
	(i) capsulotomy;	
	(ii) joint release;	
	(iii) neurolysis;	
	(iv) debridement and grafting of cysts;	
	(v) synovectomy;	
	(v) synovectomy; (vi) joint debridement;	
		and) (Assist)
New	other than a service associated with a service to which item 30023 applies (H) (Ana	ats.) (ASSISt.)
49782	Fee: \$588.35Benefit: 75% = \$441.30Reconstruction of major tendon of ankle, by any method, including:	

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDIC
	(a) osteotomy of hindfoot, with internal fixation; and
	(b) lengthening of major tendon of ankle; and
	(c) any of the following (if performed):
	(i) synovial biopsy;
	(ii) synovectomy;
	(iii) adjacent tendon transfer;
	(iv) turn down flaps;
	other than a service associated with a service to which item 49718 applies (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$1,028.70 <b>Benefit:</b> 75% = \$771.55
	Complete excision of one or more ganglia or bursae:
	(a) including excision of bony prominence or mucinous cyst of ankle, hindoot or midfoot joint and surrounding tissues; and
	(b) including any of the following (if performed):
	(i) arthrotomy;
	(ii) synovectomy;
	(iii) osteophyte resections;
	(iv) neurolysis;
	(v) capsular or ligament repair;
	(vi) skin closure, by any method;
	other than a service associated with a service to which item 30023 applies—each incision (H) (Anaes.) (Assist.)
<b>New</b> 49884	Fee: \$386.55 Benefit: 75% = \$289.95
	Revision of complete excision of one or more ganglia or bursae:
	(a) including excision of bony prominence or mucinous cyst of ankle, hindoot or midfoot joint and surrounding tissues; and
	(b) including any of the following (if performed):
	(i) arthrotomy;
	(ii) synovectomy;
	(iii) osteophyte resections;
<b>New</b> 49890	(iv) neurolysis;

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDI
	(v) capsular or ligament repair;
	(vi) skin closure, by any method;
	other than a service associated with a service to which item 30023 or 49884 applies—each incision (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$521.80 <b>Benefit:</b> 75% = \$391.35
	FOOT
	Surgery of joint of hindfoot (other than ankle or first metatarsophalangeal joint), by arthroscopic means, including any of the following (if performed):
	(a) cartilage treatment;
	(b) removal of loose bodies;
	(c) synovectomy;
	(d) excision of joint osteophytes;
Norr	other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the ankle by arthroscopic means—one joint (H) (Anaes.) (Assist.)
<b>New</b> 49730	<b>Fee:</b> \$636.75 <b>Benefit:</b> 75% = \$477.60
	Endoscopy of large tendons of foot, including any of the following (if performed):
	(a) debridement of tendon and sheath;
	(b) removal of loose bodies;
	(c) synovectomy;
	(d) excision of tendon impingement;
	other than a service associated with a service to which item 49718 or 49724 applies (H) (Anaes.) (Assist.)
<b>New</b> 49732	<b>Fee:</b> \$636.75 <b>Benefit:</b> 75% = \$477.60
	Arthrotomy of hindfoot, midfoot or metatarsophalangeal joint, for infection, including:
	(a) removal of loose bodies; and
	(b) either or both of the following:
	(i) joint debridement;
	(ii) release of joint contracture;
N.T.	—each incision (H) (Anaes.) (Assist.)
<b>New</b> 49734	<b>Fee:</b> \$342.90 <b>Benefit:</b> 75% = \$257.20
<b>New</b> 49736	Transfer of major tendon of foot and ankle, including:

T8. SUR	RGICAL OPERATIONS 1	5. ORTHOPAEDIC
	(a) split or whole transfer to contralateral side of foot; and	
	(b) passage of posterior or anterior tendon to, or through, interosseous membrane; a	nd
	(c) any of the following (if performed):	
	(i) synovial biopsy;	
	(ii) synovectomy;	
	(iii) tendon lengthening;	
	(iv) insetting of tendon	
	(H) (Anaes.) (Assist.)	
	<b>Fee:</b> \$685.85 <b>Benefit:</b> 75% = \$514.40	
	Stabilisation of ligament of talonavicular or metatarsophalangeal joint, including an performed):	y of the following (if
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) local tendon transfer;	
	(e) joint debridement	
	(H) (Anaes.) (Assist.)	
<b>New</b> 49738	<b>Fee:</b> \$489.75 <b>Benefit:</b> 75% = \$367.35	
	Arthroereisis of subtalar joint, including any of the following (if performed):	
	(a) capsulotomy;	
	(b) synovectomy;	
	(c) joint debridement	
	(H) (Anaes.) (Assist.)	
<b>New</b> 49760	<b>Fee:</b> \$367.35 <b>Benefit:</b> 75% = \$275.55	
	Stabilisation of metatarsophalangeal joint at metatarsal, including any of the follows	ing (if performed):
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) osteotomy, with or without fixation;	
<b>New</b> 49761	(e) local tendon transfer;	

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDIC
	(f) local tendon lengthening or release;
	(g) ligament repair;
	(h) joint debridement;
	—one metatarsal (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$538.80 <b>Benefit:</b> 75% = \$404.10
	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) osteotomy, with or without fixation;
	(e) local tendon transfer;
	(f) local tendon lengthening or release;
	(g) ligament repair;
	(h) joint debridement;
	—2 metatarsals (H) (Anaes.) (Assist.)
<b>New</b> 49762	<b>Fee:</b> \$597.90 <b>Benefit:</b> 75% = \$448.45
	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) osteotomy, with or without fixation;
	(e) local tendon transfer;
	(f) local tendon lengthening or release;
	(g) ligament repair;
	(h) joint debridement;
	—3 metatarsals (H) (Anaes.) (Assist.)
<b>New</b> 49763	<b>Fee:</b> \$657.00 <b>Benefit:</b> 75% = \$492.75
	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed):
<b>New</b> 49764	(a) capsulotomy;

т8. \$	URGICAL OPERATIONS 15. ORTHOPAEDIC
	(b) joint release;
	(c) synovectomy;
	(d) osteotomy, with or without fixation;
	(e) local tendon transfer;
	(f) local tendon lengthening or release;
	(g) ligament repair;
	(h) joint debridement;
	-4 metatarsals (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$716.15 <b>Benefit:</b> 75% = \$537.15
	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) osteotomy, with or without fixation;
	(e) local tendon transfer;
	(f) local tendon lengthening or release;
	(g) ligament repair;
	(h) joint debridement;
	—5 metatarsals (H) (Anaes.) (Assist.)
<b>New</b> 49765	<b>Fee:</b> \$775.20 <b>Benefit:</b> 75% = \$581.40
	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) osteotomy, with or without fixation;
	(e) local tendon transfer;
	(f) local tendon lengthening or release;
	(g) ligament repair;
<b>New</b> 49766	(h) joint debridement;

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDIC
	—6 metatarsals (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$834.40 <b>Benefit:</b> 75% = \$625.80
	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) osteotomy, with or without fixation;
	(e) local tendon transfer;
	(f) local tendon lengthening or release;
	(g) ligament repair;
	(h) joint debridement;
	—7 metatarsals (H) (Anaes.) (Assist.)
<b>New</b> 49767	<b>Fee:</b> \$893.50 <b>Benefit:</b> 75% = \$670.15
	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) osteotomy, with or without fixation;
	(e) local tendon transfer;
	(f) local tendon lengthening or release;
	(g) ligament repair;
	(h) joint debridement;
	-8 metatarsals (H) (Anaes.) (Assist.)
<b>New</b> 49768	<b>Fee:</b> \$952.60 <b>Benefit:</b> 75% = \$714.45
47700	Unilateral correction of hallux valgus or varus deformity, by osteotomy of first metatarsal and proximal phalanx of first toe, with internal fixation of both bones, including any of the following (if performed):
	(a) exostectomy;
	(b) removal of bursae;
	(c) synovectomy;
<b>New</b> 49769	(d) capsule repair;

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC
	(e) capsule or tendon release or transfer
	(H) (Anaes.) (Assist.)
	<b>Fee:</b> \$942.85 <b>Benefit:</b> 75% = \$707.15
	Bilateral correction of hallux valgus or varus deformity, by osteotomy of first metatarsal and proximal phalanx of first toe, with internal fixation of both bones, including any of the following (if performed):
	(a) exostectomy;
	(b) removal of bursae;
	(c) synovectomy;
	(d) capsule repair;
	(e) capsule or tendon release or transfer
	(H) (Anaes.) (Assist.)
<b>New</b> 49770	<b>Fee:</b> \$1,567.20 <b>Benefit:</b> 75% = \$1175.40
	Excision of rheumatoid nodules or gouty tophi, excluding aftercare, including any of the following (if performed):
	(a) capsulotomy;
	(b) debridement of ligament or tendon (or both);
	(c) release of ligament or tendon (or both);
	(d) excision of tubercle or osteophyte;
	—each incision (H) (Anaes.) (Assist.)
<b>New</b> 49772	<b>Fee:</b> \$341.15 <b>Benefit:</b> 75% = \$255.90
	Revision of excision of intermetatarsal or digital neuroma, including any of the following (if performed):
	(a) release of tissues;
	(b) excision of bursae;
	(c) neurolysis;
	other than a service associated with a service to which item 30023 applies—one web space (H) (Anaes.) (Assist.)
<b>New</b> 49773	<b>Fee:</b> \$422.85 <b>Benefit:</b> 75% = \$317.15
	Release of tarsal tunnel, including any of the following (if performed):
	(a) release of ligaments;
	(b) synovectomy;
<b>New</b> 49774	(c) neurolysis;

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	other than a service associated with a service to which item 30023 applies—c (Assist.)	one foot (H) (Anaes.)
	<b>Fee:</b> \$288.00 <b>Benefit:</b> 75% = \$216.00	
	Revision of release of tarsal tunnel, including any of the following (if perform	ned):
	(a) release of ligaments;	
	(b) synovectomy;	
	(c) neurolysis;	
Norm	other than a service associated with a service to which item 30023 applies—c (Assist.)	one foot (H) (Anaes.)
<b>New</b> 49775	<b>Fee:</b> \$388.85 <b>Benefit:</b> 75% = \$291.65	
	Revision of arthrodesis of joint of hindfoot, by open or arthroscopic means, v fixation by any method, including any of the following (if performed):	vith internal or external
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) removal of osteophytes at joint;	
	(e) removal of hardware;	
	(f) neurolysis;	
	(g) osteotomy of non-union or malunion;	
	other than a service associated with a service to which item 30023 applies (H	) (Anaes.) (Assist.)
<b>New</b> 49776	<b>Fee:</b> \$1,223.00 <b>Benefit:</b> 75% = \$917.25	
	Arthrodesis of joint of midfoot, by open or arthroscopic means, with internal method, including any of the following (if performed):	or external fixation by any
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) removal of osteophytes at joint;	
	—one joint (H) (Anaes.) (Assist.)	
<b>New</b> 49777	<b>Fee:</b> \$724.15 <b>Benefit:</b> 75% = \$543.15	
	Arthrodesis of joints of midfoot, by open or arthroscopic means, with international method, including any of the following (if performed):	l or external fixation by any
<b>New</b> 49778	(a) capsulotomy;	

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDI	С
	(b) joint release;	
	(c) synovectomy;	
	(d) removal of osteophytes at joints;	
	-2 joints (H) (Anaes.) (Assist.)	
	<b>Fee:</b> \$1,086.25 <b>Benefit:</b> 75% = \$814.70	
	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed):	у
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) removal of osteophytes at joints;	
	—3 joints (H) (Anaes.) (Assist.)	
<b>New</b> 49779	<b>Fee:</b> \$1,267.25 <b>Benefit:</b> 75% = \$950.45	
	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed):	у
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) removal of osteophytes at joints;	
	—4 joints (H) (Anaes.) (Assist.)	
<b>New</b> 49780	<b>Fee:</b> \$1,448.30 <b>Benefit:</b> 75% = \$1086.25	
	Revision of arthrodesis of joint of midfoot, with internal or external fixation by any method, including any of the following (if performed):	
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) removal of ostephytes at joint;	
	(e) removal of hardware;	
	(f) osteotomy of non-union or malunion;	
	—one joint (H) (Anaes.) (Assist.)	
<b>New</b> 49781	<b>Fee:</b> \$1,086.25 <b>Benefit:</b> 75% = \$814.70	

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	Excisional or interpositional arthroplasty of metatarsophalangeal or tarson of the following (if performed):	netatarsal joints, including any
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) local tendon transfer;	
	(e) joint debridement;	
New	-4 joints (H) (Anaes.) (Assist.)	
49784	<b>Fee:</b> \$901.60 <b>Benefit:</b> 75% = \$676.20	
	Excisional or interpositional arthroplasty of metatarsophalangeal or tarson of the following (if performed):	netatarsal joints, including any
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) local tendon transfer;	
	(e) joint debridement;	
<b>New</b> 49785	<b>Fee:</b> \$1,014.25 <b>Benefit:</b> 75% = \$760.70	
	Excisional or interpositional arthroplasty of metatarsophalangeal or tarson of the following (if performed):	netatarsal joints, including any
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) local tendon transfer;	
	(e) joint debridement;	
	6 joints (H) (Anaes.) (Assist.)	
<b>New</b> 49786	<b>Fee:</b> \$1,126.90 <b>Benefit:</b> 75% = \$845.20	
	Excisional or interpositional arthroplasty of metatarsophalangeal or tarson of the following (if performed):	netatarsal joints, including any
	(a) capsulotomy;	
<b>New</b> 49787	(b) joint release;	

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDI
	(c) synovectomy;
	(d) local tendon transfer;
	(e) joint debridement;
	—7 joints (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$1,239.50 <b>Benefit:</b> 75% = \$929.65
	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) local tendon transfer;
	(e) joint debridement;
<b>New</b> 49788	<b>Fee:</b> \$1,352.15 <b>Benefit:</b> 75% = \$1014.15
	Bilateral arthrodesis of first metatarsophalangeal joint, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) removal of osteophytes at joint
	(H) (Anaes.) (Assist.)
<b>New</b> 49789	<b>Fee:</b> \$1,163.05 <b>Benefit:</b> 75% = \$872.30
	Revision of arthrodesis of first metatarsophalangeal joint, including any of the following (if performed):
	(a) capsulotomy;
	(b) joint release;
	(c) synovectomy;
	(d) removal of exostosis at joint;
	(e) removal of hardware;
	(f) osteotomy of non-union or malunion
	(H) (Anaes.) (Assist.)
<b>New</b> 49790	<b>Fee:</b> \$1,010.20 <b>Benefit:</b> 75% = \$757.65

T8. SUR	GICAL OPERATIO	NS	15. ORTHOPAEDIC	
		x interphalangeal or lesser metatar nod, including any of the following	sophalangeal joint, with internal or external g (if performed):	
	(a) capsulotomy;			
	(b) joint release;			
	(c) synovectomy;			
	(d) removal of osteophytes at joint			
	(H) (Anaes.) (Assist	.)		
<b>New</b> 49791	Fee: \$458.00	<b>Benefit:</b> 75% = \$343.50		
		my or interpositional arthroplasty following (if performed):	of proximal or distal joint (or both) of lesser toe,	
	(a) internal fixation,	by any method;		
	(b) capsulotomy;			
	(c) joint release;			
	(d) synovectomy;			
	(e) removal of osteo	phytes at joints;		
	—one or 2 toes (H)	(Anaes.) (Assist.)		
<b>New</b> 49792	Fee: \$514.45	<b>Benefit:</b> 75% = \$385.85		
		my or interpositional arthroplasty following (if performed):	of proximal or distal joint (or both) of lesser toe,	
	(a) internal fixation,	by any method;		
	(b) capsulotomy;			
	(c) joint release;			
	(d) synovectomy;			
	(e) removal of osteo	phytes at joints;		
	—3 toes (H) (Anaes	s.) (Assist.)		
<b>New</b> 49793	Fee: \$600.20	<b>Benefit:</b> 75% = \$450.15		
		my or interpositional arthroplasty following (if performed):	of proximal or distal joint (or both) of lesser toe,	
	(a) internal fixation,	by any method;		
	(b) capsulotomy;			
<b>New</b> 49794	(c) joint release;			

T8. SUR	GICAL OPERAT	IONS	15. ORTHOPAEDIC
	(d) synovectomy	;	
	(e) removal of os	steophytes at joints;	
	—4 toes (H) (An	aes.) (Assist.)	
	Fee: \$685.90	<b>Benefit:</b> 75% = \$514.45	
		cotomy or interpositional arthroplasty of proximal or distal joint ( the following (if performed):	(or both) of lesser toe,
	(a) internal fixati	on, by any method;	
	(b) capsulotomy;		
	(c) joint release;		
	(d) synovectomy	;	
	(e) removal of os	steophytes at joints;	
	—5 toes (H) (An	aes.) (Assist.)	
<b>New</b> 49795	Fee: \$771.65	<b>Benefit:</b> 75% = \$578.75	
		cotomy or interpositional arthroplasty of proximal or distal joint ( the following (if performed):	(or both) of lesser toe,
	(a) internal fixati	on, by any method;	
	(b) capsulotomy;	;	
	(c) joint release;		
	(d) synovectomy	;	
	(e) removal of os	steophytes at joints;	
	—6 toes (H) (An	aes.) (Assist.)	
<b>New</b> 49796	Fee: \$857.40	<b>Benefit:</b> 75% = \$643.05	
		botomy or interpositional arthroplasty of proximal or distal joint ( the following (if performed):	(or both) of lesser toe,
	(a) internal fixati	on, by any method;	
	(b) capsulotomy;	;	
	(c) joint release;		
	(d) synovectomy	;	
	(e) removal of os	steophytes at joints;	
	—7 toes (H) (An	naes.) (Assist.)	
<b>New</b> 49797	Fee: \$943.10	<b>Benefit:</b> 75% = \$707.35	

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC
	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joincluding any of the following (if performed):	int (or both) of lesser toe,
	(a) internal fixation, by any method;	
	(b) capsulotomy;	
	(c) joint release;	
	(d) synovectomy;	
	(e) removal of osteophytes at joints;	
	-8 toes (H) (Anaes.) (Assist.)	
New		
49798	Fee:         \$1,028.85         Benefit:         75% = \$771.65	
	Primary repair of flexor or extensor tendon of foot, including either or both o performed):	f the following (if
	(a) synovial biopsy;	
	(b) synovectomy;	
Amend	—one toe (Anaes.) (Assist.)	
Fee 49800	<b>Fee:</b> \$137.15 <b>Benefit:</b> 75% = \$102.90 85% = \$116.60	
	Secondary repair of flexor or extensor tendon of foot, including either or both performed):	n of the following (if
	(a) synovial biopsy;	
	(b) synovectomy;	
Amend	—one toe (Anaes.) (Assist.)	
Fee 49803	<b>Fee:</b> \$176.35 <b>Benefit:</b> 75% = \$132.30 85% = \$149.90	
Amend	Subcutaneous tenotomy of foot, by small percutaneous incisions—one or mo	re tendons (Anaes.)
Fee 49806	<b>Fee:</b> \$137.15 <b>Benefit:</b> 75% = \$102.90 85% = \$116.60	
	Open tenotomy or lengthening of foot, by open incision, with or without teno both of the following (if performed):	plasty, including either or
	(a) synovial biopsy;	
	(b) synovectomy;	
Amend	—one toe (Anaes.) (Assist.)	
<b>Fee</b> 49809	<b>Fee:</b> \$225.25 <b>Benefit:</b> 75% = \$168.95 85% = \$191.50	
	Advancement of tendon or ligament transfer of foot, including:	
	(a) side to side transfer, harvesting and transfer for ligament or minor foot ter	don reconstruction: and
<b>Amend</b> <b>Fee</b> 49812	(b) either or both of the following (if performed):	

T8. SURG	GICAL OPERA	TIONS	15. ORTHOPAEDIC	
	(i) synovia	al biopsy;		
	(ii) synove	ectomy;		
	—one major ter	ndon or toe (H) (Anaes.) (Assist.)		
	Fee: \$450.50	<b>Benefit:</b> 75% = \$337.90		
	Triple arthrodes the following (i	sis of hindfoot joints, with internal or external fixation by a if performed):	ny method, including any of	
	(a) capsulotomy	у;		
	(b) joint release	2,		
	(c) synovectom	ıy;		
	(d) removal of o	osteophytes at joints		
Amend	(H) (Anaes.) (A	Assist.)		
<b>Fee</b> 49815	Fee: \$1,426.85	<b>Benefit:</b> 75% = \$1070.15		
Amend	Release of plan	tar fascia, including excision of calcaneal spur (if performe	ed) (H) (Anaes.) (Assist.)	
<b>Fee</b> 49818	Fee: \$284.00	<b>Benefit:</b> 75% = \$213.00		
		nterpositional arthroplasty of metatarsophalangeal or tarsom g (if performed):	netatarsal joint, including any	
	(a) capsulotomy	у;		
	(b) joint release	;;		
	(c) synovectom	ıy;		
	(d) local tendon transfer;			
	(e) joint debridement			
Amend	—one joint (H)	(Anaes.) (Assist.)		
Fee 49821	Fee: \$450.50	<b>Benefit:</b> 75% = \$337.90		
		nterpositional arthroplasty of metatarsophalangeal or tarsom g (if performed):	netatarsal joint, including any	
	(a) capsulotomy	у;		
	(b) joint release	s. ,		
	(c) synovectom	ıy;		
	(d) local tendon	n transfer;		
	(e) joint debride	ement;		
<b>Amend</b> <b>Fee</b> 49824	—2 joints (H) (	(Anaes.) (Assist.)		

T8. SUR	GICAL OPERATIO	NS	15. ORTHOPAEDIC		
	Fee: \$788.70	<b>Benefit:</b> 75% = \$591.55			
	Unilateral correction any of the following	on of hallux valgus or varus deformity of the fog (if performed):	oot, by local tendon transfer, including		
	(a) exostectomy;				
	(b) removal of burs	sae;			
	(c) synovectomy;				
	(d) capsule repair;				
	(e) capsule or tende	on release or transfer			
Amend Fee	(H) (Anaes.) (Assis	st.)			
49827	Fee: \$489.75	<b>Benefit:</b> 75% = \$367.35			
	Bilateral correction any of the followin	n of hallux valgus or varus deformity of the foo g (if performed):	ot, by local tendon transfer, including		
	(a) exostectomy;				
	(b) removal of burs	sae;			
	(c) synovectomy;				
	(d) capsule repair;				
	(e) capsule or tendon release or transfer				
Amend Fee	(H) (Anaes.) (Assis	st.)			
49830	Fee: \$857.15	<b>Benefit:</b> 75% = \$642.90			
		on of hallus valgus or varus deformity of the fo ation, including any of the following (if perfor			
	(a) exostectomy;				
	(b) removal of burs	sae;			
	(c) synovectomy;				
	(d) capsule repair;				
	(e) capsule or tende	on release or transfer			
Amend Fee	(H) (Anaes.) (Assis	st.)			
49833	Fee: \$538.80	<b>Benefit:</b> 75% = \$404.10			
		n of hallus valgus or varus deformity of the foo action, including any of the following (if perfor			
<b>Amend</b> <b>Fee</b> 49836	(a) exostectomy;				

T8. SURG	ICAL OPERATIONS 15. ORTHOPAEDIC
	(b) removal of bursae;
	(c) synovectomy;
	(d) capsule repair;
	(e) capsule or tendon release or transfer
	(H) (Anaes.) (Assist.)
	<b>Fee:</b> \$930.65 <b>Benefit:</b> 75% = \$698.00
	Unilateral correction of hallus valgus or varus deformity of the foot, by osteotomy of first metatarsal, with internal fixation, including any of the following (if performed):
	(a) exostectomy;
	(b) removal of bursae;
	(c) synovectomy;
	(d) capsule repair;
	(e) capsule or tendon release or transfer
Amend	(H) (Anaes.) (Assist.)
<b>Fee</b> 49837	<b>Fee:</b> \$673.45 <b>Benefit:</b> 75% = \$505.10
	Bilateral correction of hallus valgus or varus deformity of the foot by osteotomy of first metatarsal, with internal fixation or arthrodesis of first metatarsophalangeal joint, including any of the following (if performed):
	(a) exostectomy;
	(b) removal of bursae;
	(c) synovectomy;
	(d) capsule repair;
	(e) capsule or tendon release or transfer
Amend	(H) (Anaes.) (Assist.)
Fee 49838	<b>Fee:</b> \$1,163.05 <b>Benefit:</b> 75% = \$872.30
	Total replacement of first metatarsophalangeal joint, with replacement of both joint surfaces, including any of the following (if performed):
	(a) capsulotomy;
	(b) synovectomy;
	(c) joint debridement
Amend	(H) (Anaes.) (Assist.)
<b>Fee</b> 49839	<b>Fee:</b> \$538.80 <b>Benefit:</b> 75% = \$404.10

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC
	Unilateral arthrodesis of first metatarsophalangeal joint, by open or arthro external fixation by any method, including any of the following (if perfor	
	(a) capsulotomy;	
	(b) joint release;	
	(c) synovectomy;	
	(d) removal of osteophytes at joints	
Amend	(H) (Anaes.) (Assist.)	
<b>Fee</b> 49845	Fee: \$673.45 Benefit: 75% = \$505.10	
	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or dist including any of the following (if performed):	tal (or both) joints of lesser toe,
	(a) internal fixation, by any method;	
	(b) capsulotomy;	
	(c) tendon lengthening;	
	(d) joint release;	
	(e) synovectomy;	
	(f) removal of osteophytes at joints;	
Amend	—one toe (H) (Anaes.)	
<b>Fee</b> 49851	<b>Fee:</b> \$450.50 <b>Benefit:</b> 75% = \$337.90	
Amend	Radical plantar fasciotomy or fasciectomy, with extensive incision into fa including excision of calcaneal spur (if performed), other than a service a which 49818 applies (H) (Anaes.) (Assist.)	
<b>Fee</b> 49854	<b>Fee:</b> \$391.80 <b>Benefit:</b> 75% = \$293.85	
	Hemi joint replacement of first or lesser metatarsophalangeal joint, inclue performed):	ding any of the following (if
	(a) capsulotomy;	
	(b) synovectomy;	
	(c) joint debridement	
Amend	(H) (Anaes.) (Assist.)	
Fee 49857	<b>Fee:</b> \$362.45 <b>Benefit:</b> 75% = \$271.85	
	Synovectomy of metatarsophalangeal joints, including any of the followi	ing (if performed):
	(a) capsulotomy;	
<b>Amend</b> <b>Fee</b> 49860	(b) debridement;	

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEI	C
	(c) release of ligament or tendon (or both);	
	<b>Fee:</b> \$338.45 <b>Benefit:</b> 75% = \$253.85	
	Excision of intermetatarsal or digital neuroma, including any of the following (if performed):	
	(a) release of metatarsal or digital ligament;	
	(b) excision of bursae;	
	(c) neurolysis;	
Amend Fee	other than a service associated with a service to which item 30023 applies—one web space (H) (Anae (Assist.)	s.)
49866	<b>Fee:</b> \$313.25 <b>Benefit:</b> 75% = \$234.95	
Amend	Talipes equinovarus, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation—each attendance (Anaes.)	
<b>Fee</b> 49878	Fee: \$58.75 Benefit: 75% = \$44.10 85% = \$49.95	
	Complete excision of one or more ganglia or bursae:	
	(a) including excision of bony prominence or mucinous cyst of interphalangeal or metatarsophalangea joint and surrounding tissues; and	ıl
	(b) including any of the following (if performed):	
	(i) arthrotomy;	
	(ii) synovectomy;	
	(iii) osteophyte resections;	
	(iv) neurolysis;	
	(v) skin closure, by any local method;	
	other than a service associated with a service to which item 30023 applies—each incision (H) (Anaes. (Assist.)	.)
<b>New</b> 49881	<b>Fee:</b> \$228.85 <b>Benefit:</b> 75% = \$171.65	
	Revision of complete excision of one or more ganglia or bursae:	
	(a) including excision of bony prominence or mucinous cyst of interphalangeal or metatarsophalangea joint and surrounding tissues; and	ıl
	(b) including any of the following (if performed):	
	(i) arthrotomy;	
	(ii) synovectomy;	
<b>New</b> 49887	(iii) osteophyte resections;	

T8. SURGICAL OPERATIONS 15. ORTHOPAEDIC			
	(iv) neurolysis;		
	(v) skin closure, by	v) skin closure, by any method;	
	other than a service (Anaes.) (Assist.)	associated with a service to which item 30023 or 49881 applies—each incision (H)	
	Fee: \$309.00	<b>Benefit:</b> 75% = \$231.75	
	OTHER JOINTS		
Amend	Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)		
Fee 50112	Fee: \$375.70	<b>Benefit:</b> 75% = \$281.80	
Amend Fee	Manipulation of one or more joints, excluding spine, other than a service associated with a service which another item in this Group applies (H) (Anaes.)		
50115	Fee: \$148.80	<b>Benefit:</b> 75% = \$111.60	
	Arthrodesis of joint of hindfoot, by any method, with internal or external fixation by any method, including any of the following (if performed):		
	(a) capsulotomy;		
	(b) joint release;		
	(c) synovectomy;		
	(d) removal of osteophytes at joints;		
Amend Fee	—one joint (H) (Anaes.) (Assist.)		
50118	Fee: \$815.30	<b>Benefit:</b> 75% = \$611.50	
Amend Fee	Joint or joints, appli (Assist.)	cation of external fixator to, other than for treatment of fractures (H) (Anaes.)	
50130	Fee: \$324.95	<b>Benefit:</b> 75% = \$243.75	
		MALIGNANT DISEASE	
<b>Amend</b> <b>Fee</b> 50200	Core needle biopsy aftercare (Anaes.)	of aggressive or potentially malignant bone or soft tissue tumour, excluding	
	Fee: \$195.80	<b>Benefit:</b> 75% = \$146.85 85% = \$166.45	
Amend	Incisional biopsy of (Anaes.) (Assist.)	aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare	
Fee 50201	Fee: \$342.80	<b>Benefit:</b> 75% = \$257.10 85% = \$291.40	
Amend Fee	Intralesional or marginal excision of bone or soft tissue tumour (Anaes.) (Assist.)		
50203	Fee: \$431.05	<b>Benefit:</b> 75% = \$323.30 85% = \$366.40	
<b>Amend</b> <b>Fee</b> 50206	Intralesional or mar	inal excision of bone tumour, with at least one of the following:	
	(a) autograft;		

T8. SUR	GICAL OPERATI	ONS 15. ORTHOPAEDIC
	(b) allograft;	
	(c) cementation	
	(H) (Anaes.) (Ass	ist.)
	Fee: \$636.75	<b>Benefit:</b> 75% = \$477.60
	Intralesional or m	arginal excision of bone tumour, with at least 2 of the following:
	(a) autograft;	
	(b) allograft;	
	(c) cementation	
Amend Fee	(H) (Anaes.) (Ass	ist.)
50209	Fee: \$783.80	<b>Benefit:</b> 75% = \$587.85
Amend Fee	Wide excision of scapula (H) (Ana	malignant or aggressive bone or soft tissue tumour (or both), affecting a limb, trunk or es.) (Assist.)
50212	Fee: \$1,714.30	<b>Benefit:</b> 75% = \$1285.75
Amend Fee		malignant or aggressive bone or soft tissue tumour (or both), with intercalary bone by prosthesis, allograft or autograft (H) (Anaes.) (Assist.)
50215	Fee: \$2,155.10	<b>Benefit:</b> 75% = \$1616.35
Amend		malignant or aggressive bone or soft tissue tumour (or both), with reconstruction, throdesis of adjacent joint, by prosthesis, allograft or autograft (H) (Anaes.) (Assist.)
Fee 50218	Fee: \$2,840.95	<b>Benefit:</b> 75% = \$2130.75
Amend		malignant or aggressive bone or soft tissue tumour (or both) of pelvis, sacrum or spine, ction (H) (Anaes.) (Assist.)
Fee 50221	Fee: \$2,644.85	<b>Benefit:</b> 75% = \$1983.65
Amend Fee		malignant or bone or soft tissue tumour (or both) of pelvis, sacrum or spine, with bone defect, or one or more joints, by any technique (Anaes.) (Assist.)
50224	Fee: \$2,938.80	<b>Benefit:</b> 75% = \$2204.10 85% = \$2854.10
Amend	Treatment of mal amputation (H) (A	ignant or aggressive bone or soft tissue tumour (or both) by hindquarter or forequarter Anaes.) (Assist.)
Fee 50233	Fee: \$2,253.10	<b>Benefit:</b> 75% = \$1689.85
Amend Fee		ignant or aggressive bone or soft tissue tumour (or both), by hip disarticulation, lation or amputation through the proximal one third of the femur (H) (Anaes.) (Assist.)
50236	Fee: \$1,763.30	<b>Benefit:</b> 75% = \$1322.50
Amend Fee		ignant or aggressive bone or soft tissue tumour (or both), by amputation, other than a with a service to which item 50233 or 50236 applies (H) (Anaes.) (Assist.)
50239	Fee: \$1,175.40	<b>Benefit:</b> 75% = \$881.55
<b>New</b> 50242	Revision of endo	prosthetic replacement, if item 50218 or 50224, or an item that describes a service

T8. SUR	GICAL OPERATIO	NS	15. ORTHOPAEDIC
	substantially simila	ar to either of those items, a	applied to the initial procedure:
	(a) including any o	f the following:	
	(i) rebushing:		
	(ii) patella res	surfacing;	
	(iii) polyethy	lene exchange or similar; a	nd
	(b) excluding remo	wal of prosthetic from bone	e
	(H) (Anaes.) (Assis	st.)	
	Fee: \$881.65	<b>Benefit:</b> 75% = \$661.25	
		LIMB LENGTHENING	G AND DEFORMITY CORRECTION
New	substantially simila		50215, 50218 or 50224, or an item that describes a service plied to the initial procedure, by any technique or ist.)
50245	Fee: \$2,645.05	<b>Benefit:</b> 75% = \$1983.80	
Amend	Gradual correction	of joint deformity, with ap	pplication of external fixator (H) (Anaes.) (Assist.)
Fee 50300	Fee: \$1,204.60	<b>Benefit:</b> 75% = \$903.45	
Amend Fee	Limb lengthening, (H) (Anaes.) (Assis		h application of external fixator or intra-medullary device
50303	Fee: \$1,644.65	<b>Benefit:</b> 75% = \$1233.50	
	Bipolar limb length	nening:	
	(a) with application	n of external fixator or intra	a-medullary device; and
	(b) by any of the fo	ollowing:	
	(i) gradual di	straction;	
	(ii) bone tran	sport;	
	(iii) fixator ex	xtension, to correct for an a	adjacent joint deformity
Amend	(H) (Anaes.) (Assis	st.)	
Fee 50306	Fee: \$2,567.90	<b>Benefit:</b> 75% = \$1925.95	
Amend Fee	-		with or without insertion or removal of fixation pins, an a service to which item 50303 or 50306 applies (H)
50309	Fee: \$317.45	<b>Benefit:</b> 75% = \$238.10	
		of ring fixator or similar dev 50306, or 50309 applies	evice, other than a service associated with a service to
New 50310	Fee: \$45.40	<b>Benefit:</b> 75% = \$34.05	85% = \$38.60
			ure, of ankle joint for osteochondral large defect greater

T8. SURC	GICAL OPERATION	NS	15. ORTHOPAEDIC
<b>Fee</b> 50312	than $1.5 \text{ cm}^2$ , by arth	proscopic or open means, including any of the follow	ing (if performed):
	(a) capsulotomy;		
	(b) debridement or r	elease of ligament;	
	(c) debridement or r	elease of tendon;	
	other than a service	associated with a service to which any of the follow	ing apply:
	(d) item 49703;		
		his Schedule if the service described in the other iter oscopic procedure of the ankle	n is for the purpose of
	(H) (Anaes.) (Assist	.)	
	Fee: \$782.70	<b>Benefit:</b> 75% = \$587.05	
Amend	Release of soft tissu	e of talipes equinovarus, by open means (H) (Anaes,	) (Assist.)
Fee 50321	Fee: \$966.45	<b>Benefit:</b> 75% = \$724.85	
Amend	Revision of release	of soft tissue of talipes equinovarus, by open means	(H) (Anaes.) (Assist.)
Fee 50324	Fee: \$1,377.85	<b>Benefit:</b> 75% = \$1033.40	
Amend Fee	Post-operative manipulation, and change of plaster, of vertical, congenital talipes equinovarus or talus other than a service to which item 50321 or 50324 applies (H) (Anaes.)		
50330	Fee: \$237.95	<b>Benefit:</b> 75% = \$178.50	
	Excision of tarsal co following (if perform	palition, with interposition of muscle, fat graft or sim ned):	ilar graft, including any of the
	(a) capsulotomy;		
	(b) synovectomy;		
	(c) excision of osteo	pphytes;	
Amend Fee	-one coalition (H)	(Anaes.) (Assist.)	
50333	Fee: \$641.80	<b>Benefit:</b> 75% = \$481.35	
Num		ll, congenital talus, by percutaneous or open stabilisa (H) (Anaes.) (Assist.)	ation of talonavicular joint and
New 50335	Fee: \$641.80	<b>Benefit:</b> 75% = \$481.35	
Amend Fee	Talus, vertical, cong	genital, combined anterior and posterior reconstruction	on (H) (Anaes.) (Assist.)
50336	Fee: \$959.40	<b>Benefit:</b> 75% = \$719.55	
Amend Fee	Tibialis anterior or t	ibialis posterior tendon transfer (split or whole) (H)	(Anaes.) (Assist.)
50339	Fee: \$614.40	<b>Benefit:</b> 75% = \$460.80	
<b>Amend</b> <b>Fee</b> 50345		ormity of toe, release incorporating V-Y plasty of sk of capsule contracture (H) (Anaes.) (Assist.)	in, lengthening of extensor

T8. SUR	GICAL OPERATI	ONS 15. ORTHOPAEDIC
	Fee: \$363.95	<b>Benefit:</b> 75% = \$273.00
Amend Fee	Knee, deformity of anaesthesia (H) (A	of, post-operative manipulation and change of plaster, performed under general Anaes.)
50348	Fee: \$237.95	<b>Benefit:</b> 75% = \$178.50
Amend Fee	Treatment of deve (Anaes.) (Assist.)	elopmental dislocation of hip, by open reduction, including application of hip spica (H)
50351	Fee: \$1,661.95	<b>Benefit:</b> 75% = \$1246.50
Amend Fee		elopmental dysplasia of hip, including supervision of initial application of splint, ther than a service to which another item in this Group applies (Anaes.)
50352	Fee: \$58.75	<b>Benefit:</b> 75% = \$44.10 85% = \$49.95
<b>Amend</b> <b>Fee</b> 50354	Resection and fix <b>Fee:</b> \$1,363.20	ation of congenital pseudarthrosis of tibia (Anaes.) (Assist.) <b>Benefit:</b> 75% = \$1022.40 85% = \$1278.50
Amend		n of rectus femoris or medial or lateral hamstring (H) (Anaes.) (Assist.)
<b>Fee</b> 50357	Fee: \$584.30	<b>Benefit:</b> 75% = \$438.25
Amend Fee	Combined medial	l and lateral hamstring tendon transfer (H) (Anaes.) (Assist.)
50360	Fee: \$678.05	<b>Benefit:</b> 75% = \$508.55
Amend Fee	including release	or release of knee contracture, with multiple tendon lengthening or tenotomies, of joint capsule (if performed), other than a service associated with a service to which his Schedule applies if the service described in the other item is for the purpose of knee (Anaes.) (Assist.)
50369	Fee: \$678.05	<b>Benefit:</b> 75% = \$508.55
Amend Fee 50372	release of joint ca	r release of knee contracture, with multiple tendon lengthening or tenotomies, including apsule (if performed), other than a service associated with a service to which another dule applies if the service described in the other item is for the purpose of knee (Anaes.) (Assist.) <b>Benefit:</b> 75% = \$892.65
	Unilateral medial	release of hip contracture, with lengthening or division of the adductors and psoas,
Amend Fee	0	n of obturator nerve (if performed) (H) (Anaes.) (Assist.)
50375	<b>Fee:</b> \$519.30	<b>Benefit:</b> 75% = \$389.50
Amend Fee	Bilateral medial release of hip contracture, with lengthening or division of adductors and psoas, including division of obturator nerve (if performed) (H) (Anaes.) (Assist.)	
50378	Fee: \$908.85	<b>Benefit:</b> 75% = \$681.65
Amend Fee	Unilateral anterior release of hip contracture, with lengthening or division of hip flexors and psoas, including division of joint capsule (if performed) (H) (Anaes.) (Assist.)	
50381	Fee: \$678.05	<b>Benefit:</b> 75% = \$508.55
		release of hip contracture, with lengthening or division of hip flexors and psoas,
Amend Fee	including division	n of joint capsule (if performed) (H) (Anaes.) (Assist.)

SICAL OPERATIC	INS	15. ORTHOPAEDIC
11	<b>U I I</b>	erebral palsy, or other
Fee: \$237.95	<b>Benefit:</b> 75% = \$178.50	
Schedule applies if	the service in the other item is for the purpose of perf	
Fee: \$879.90	<b>Benefit:</b> 75% = \$659.95	
		med) (H) (Anaes.) (Assist.)
. ,		
-		nd or foot, including any of the
(a) splitting of pha	lanx or phalanges;	
(b) ligament recon	struction;	
(c) joint reconstruc	tion	
(H) (Anaes.) (Assis	st.)	
Fee: \$483.40	<b>Benefit:</b> 75% = \$362.55	
Forearm, radial apl (Assist.)	lasia or dysplasia (radial club hand), centralisation or r	adialisation of (H) (Anaes.)
Fee: \$959.40	<b>Benefit:</b> 75% = \$719.55	
		y resection of the distal femur
Fee: \$1,363.20	<b>Benefit:</b> 75% = \$1022.40 85% = \$1278.50	
Fee: \$1,839.25	<b>Benefit:</b> 75% = \$1379.45 85% = \$1754.55	
Fee: \$1,363.20	<b>Benefit:</b> 75% = \$1022.40 85% = \$1278.50	
Patella, congenital	dislocation of, reconstruction of the quadriceps (H) (A	Anaes.) (Assist.)
Fee: \$1,125.20	<b>Benefit:</b> 75% = \$843.90	
Tibia, fibula or both, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.)		ia, with internal fixation
Fee: \$1,038.65	<b>Benefit:</b> 75% = \$779.00 85% = \$953.95	
Fee: \$483.40	<b>Benefit:</b> 75% = \$362.55	
	Application of cast neuromuscular corr Fee: \$237.95 Acetabular shelf pr Schedule applies if (H) (Anaes.) (Assis Fee: \$879.90 Multiple peri-aceta Fee: \$2,889.90 Amputation of con following (if perfor (a) splitting of pha (b) ligament reconst (c) joint reconstruct (H) (Anaes.) (Assis Fee: \$483.40 Forearm, radial apl (Assist.) Fee: \$959.40 Lower limb deficite and proximal tibia Fee: \$1,363.20 Lower limb deficite and proximal tibia Fee: \$1,363.20 Lower limb deficite and proximal tibia Fee: \$1,363.20 Patella, congenital Fee: \$1,125.20 Tibia, fibula or bot (Anaes.) (Assist.) Fee: \$1,038.65 Removal of one or hereditary multiple	Application of cast under general anaesthesia, for patient with perthes, concernmuscular conditions, affecting hips or knees (H) (Anaes.)Fee: \$237.95Benefit: 75% = \$178.50Acetabular shelf procedure, other than a service associated with a serviceSchedule applies if the service in the other item is for the purpose of perf(H) (Anaes.) (Assist.)Fee: \$879.90Benefit: 75% = \$659.95Multiple peri-acetabular osteotomy, including internal fixation (if performFee: \$2,889.90Benefit: 75% = \$2167.45Amputation of congenital abnormalities or duplication of digits of the hatfollowing (if performed):(a) splitting of phalanx or phalanges;(b) ligament reconstruction;(c) joint reconstruction(H) (Anaes.) (Assist.)Fee: \$483.40Benefit: 75% = \$362.55Forearm, radial aplasia or dysplasia (radial club hand), centralisation or r(Assist.)Fee: \$1,363.20Benefit: 75% = \$102.240Fee: \$1,363.20Benefit: 75% = \$102.240Lower limb deficiency, treatment of congenital deficiency of the femure band proximal tibia followed by knee fusion and rotationplasty (Anaes.) (AFee: \$1,363.20Benefit: 75% = \$1379.45Lower limb deficiency, treatment of congenital deficiency of the tibia byinvolving transfer of fibula or tibia, and repair of quadriceps mechanismFee: \$1,363.20Benefit: 75% = \$1379.45Rene limb deficiency, treatment of congenital deficiency of the tibia byinvolving transfer of fibula or bibla, and repair of quadriceps mechanismFee: \$1,125.20Benefit: 75% = \$102.240Ret:

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC
	Percutaneous drilling of osteochondritis dessicans or other osteochon	dral lesion, for a patient:
	(a) with open growth plates; or	
	(b) less than 18 years of age	
	(H) (Anaes.) (Assist.)	
<b>New</b> 50428	<b>Fee:</b> \$807.05 <b>Benefit:</b> 75% = \$605.30	
	SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN	WITH CEREBRAL PALSY
	Unilateral single event multilevel surgery, for a patient less than 18 years cerebral palsy, comprising 3 or more of the following:	ears of age with hemiplegic
	(a) lengthening of a contracted muscle tendon unit or units by tendon fractional lengthening or intramuscular lengthening;	lengthening, muscle recession,
	(b) correction of muscle imbalance by transfer of a tendon or tendons	;
	(c) correction of femoral torsion by rotational osteotomy of the femu	Γ;
	(d) correction of tibial torsion by rotational osteotomy of the tibia;	
	(e) correction of joint instability by varus derotation osteotomy of the synovectomy if performed, or os calcis lengthening;	e femur, subtalar arthrodesis with
	conjoint surgery, principal specialist surgeon, including fluoroscopy a	and aftercare (H) (Anaes.) (Assist.)
<b>Amend</b> <b>Fee</b> 50450	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$1,276.65 <b>Benefit:</b> 75% = \$957.50	
	Unilateral single event multilevel surgery, for a patient less than 18 ye cerebral palsy, comprising 3 or more of the following:	ears of age with hemiplegic
	(a) lengthening of a contracted muscle tendon unit or units by tendon fractional lengthening or intramuscular lengthening;	lengthening, muscle recession,
	(b) correction of muscle imbalance by transfer of a tendon or tendons	;;
	(c) correction of femoral torsion by rotational osteotomy of the femur	r;
	(d) correction of tibial torsion by rotational osteotomy of the tibia;	
	(e) correction of joint instability by varus derotation osteotomy of the synovectomy if performed, or os calcis lengthening;	e femur, subtalar arthrodesis with
	conjoint surgery, conjoint specialist surgeon, including fluoroscopy a (Anaes.) (Assist.)	nd excluding aftercare (H)
<b>Amend</b> <b>Fee</b> 50451	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,276.65 Benefit: 75% = \$957.50	
	Bilateral single event multilevel surgery, for a patient less than 18 year palsy, that comprises:	ars of age with diplegic cerebral
<b>Amend</b> <b>Fee</b> 50455	(a) lengthening of a contracted muscle tendon unit or units by tendon fractional lengthening or intramuscular lengthening; and	lengthening, muscle recession,

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC			
	(b) correction of muscle imbalance by transfer of a tendon or tendons;				
	conjoint surgery, principal specialist surgeon, including fluoroscopy and afterca	are (H) (Anaes.) (Assist.)			
	(See para TN.8.118 of explanatory notes to this Category) Fee: $$1,445.70$ Benefit: $75\% = $1084.30$				
	Bilateral single event multilevel surgery, for a patient less than 18 years of age palsy, that comprises:	with diplegic cerebral			
	(a) lengthening of a contracted muscle tendon unit or units by tendon lengthening fractional lengthening or intramuscular lengthening; and	ng, muscle recession,			
	(b) correction of muscle imbalance by transfer of a tendon or tendons;				
	conjoint surgery, conjoint specialist surgeon, including fluoroscopy and exclude (Assist.)	ing aftercare (H) (Anaes.)			
<b>Amend</b> <b>Fee</b> 50456	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$1,445.70 <b>Benefit:</b> 75% = \$1084.30				
	Bilateral single event multilevel surgery, for a patient less than 18 years of age palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteoton				
	(a) lengthening of a contracted muscle tendon unit or units by tendon lengthening fractional lengthening or intramuscular lengthening; and	ng, muscle recession,			
	(b) correction of muscle imbalance by transfer of a tendon or tendons; and				
	(c) correction of torsional abnormality of the femur by rotational osteotomy and	d internal fixation;			
	conjoint surgery, principal specialist surgeon, including fluoroscopy and afterca	are (H) (Anaes.) (Assist.)			
<b>Amend</b> <b>Fee</b> 50460	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,158.50 <b>Benefit:</b> 75% = \$1618.90				
	Bilateral single event multilevel surgery, for a patient less than 18 years of age palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteoton				
	(a) lengthening of a contracted muscle tendon unit or units by tendon lengthening fractional lengthening or intramuscular lengthening; and	ng, muscle recession,			
	(b) correction of muscle imbalance by transfer of a tendon or tendons; and				
	(c) correction of torsional abnormality of the femur by rotational osteotomy and	l internal fixation;			
	conjoint surgery, conjoint specialist surgeon, including fluoroscopy and exclude (Assist.)	ing aftercare (H) (Anaes.)			
<b>Amend</b> <b>Fee</b> 50461	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,158.50 <b>Benefit:</b> 75% = \$1618.90				
	Bilateral single event multilevel surgery, for a patient less than 18 years of age palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies osteotomies, with:				
<b>Amend</b> <b>Fee</b> 50465	(a) lengthening of a contracted muscle tendon unit or units by tendon lengthening fractional lengthening or intramuscular lengthening; and	ng, muscle recession,			

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC
	(b) correction of muscle imbalance by transfer of a tendon or tendons; and	
	(c) correction of abnormal torsion of the femur by rotational osteotomy with in	nternal fixation; and
	(d) correction of abnormal torsion of the tibia by rotational osteotomy with inte	ernal fixation;
	conjoint surgery, principal specialist surgeon, including fluoroscopy and aftered	care (H) (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,040.20 <b>Benefit:</b> 75% = \$2280.15	
	Bilateral single event multilevel surgery, for a patient less than 18 years of age palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomics osteotomies, with:	
	(a) lengthening of a contracted muscle tendon unit or units by tendon lengthen fractional lengthening or intramuscular lengthening; and	ing, muscle recession,
	(b) correction of muscle imbalance by transfer of a tendon or tendons; and	
	(c) correction of abnormal torsion of the femur by rotational osteotomy with in	nternal fixation; and
	(d) correction of abnormal torsion of the tibia by rotational osteotomy with inter-	ernal fixation;
	conjoint surgery, conjoint specialist surgeon, including fluoroscopy and exclud (Assist.)	ding aftercare (H) (Anaes.)
<b>Amend</b> <b>Fee</b> 50466	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,040.20 Benefit: 75% = \$2280.15	
	Bilateral single event multilevel surgery, for a patient less than 18 years of age comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral bilateral foot stabilisation, with:	
	(a) lengthening of a contracted muscle tendon unit or units by tendon lengthen fractional lengthening or intramuscular lengthening; and	ing, muscle recession,
	(b) correction of muscle imbalance by transfer of a tendon or tendons; and	
	(c) correction of abnormal torsion of the femur by rotational osteotomy with in	nternal fixation; and
	(d) correction of abnormal torsion of the tibia by rotational osteotomy with inte	ernal fixation; and
	(e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion	n;
	conjoint surgery, principal specialist surgeon, including fluoroscopy and after	care (H) (Anaes.) (Assist.)
<b>Amend</b> <b>Fee</b> 50470	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,855.70 <b>Benefit:</b> 75% = \$2891.80	
	Bilateral single event multilevel surgery, for a patient less than 18 years of age comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral bilateral foot stabilisation, with:	
<b>Amend</b> <b>Fee</b> 50471	(a) lengthening of a contracted muscle tendon unit or units by tendon lengthen fractional lengthening or intramuscular lengthening; and	ing, muscle recession,

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC
	(b) correction of muscle imbalance by transfer of a tendon or tendons; and	
	(c) correction of abnormal torsion of the femur by rotational osteotomy with inter	nal fixation; and
	(d) correction of abnormal torsion of the tibia by rotational osteotomy with interna-	al fixation; and
	(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 (H) (Anaes.)
	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,855.70 <b>Benefit:</b> 75% = \$2891.80	
	Single event multilevel surgery, for a patient less than 18 years of age with dipleg the correction of crouch gait, including:	ic cerebral palsy, for
	(a) lengthening of a contracted muscle tendon unit or units by tendon lengthening fractional lengthening or intramuscular lengthening; and	, muscle recession,
	(b) correction of muscle imbalance by transfer of a tendon or tendons; and	
	(c) correction of flexion deformity at the knee by extension osteotomy of the distainternal fixation; and	ll femur including
	(d) correction of patella alta and quadriceps insufficiency by patella tendon shorte and	ening or reconstruction;
	(e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and	
	(f) correction of foot instability by os calcis lengthening or subtalar fusion;	
	conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare	e (H) (Anaes.) (Assist.)
Amend Fee 50475	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$4,449.10 <b>Benefit:</b> 75% = \$3336.85	
	Single event multilevel surgery for patients less than 18 years of age with diplegic correction of crouch gait including:	c cerebral palsy for the
	(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.	stal femur including
	(d) correction of patella alta and quadriceps insufficiency by patella tendon show	rtening/reconstruction.
	(e) correction of tibial torsion by rotational osteotomy of the tibia with internal	fixation.
	(f) correction of foot instability by os calcis lengthening or subtalar fusion.	
Amend	conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding (Assist.)	g aftercare (H) (Anaes.)
Fee 50476	(See para TN.8.118 of explanatory notes to this Category)	

T8. SUR	GICAL OPERATIO	ONS	15. ORTHOPAEDIC
	Fee: \$4,449.10	<b>Benefit:</b> 75% = \$3336.85	
		TREATMENT OF FRACTU	JRES IN PAEDIATRIC PATIENTS
Amend	Treatment of fraction open growth plates		na (or both), by closed reduction, for a patient with
Fee 50508	(See para TN.8.119, <b>Fee:</b> \$411.20	TN.8.118 of explanatory notes to <b>Benefit:</b> 75% = \$308.40 85	
Amend		ure of distal end of radius or u ent with open growth plates (H	na (or both), by open or closed reduction, with internal (Anaes.) (Assist.)
Fee 50512	(See para TN.8.119, <b>Fee:</b> \$548.70	TN.8.118 of explanatory notes to <b>Benefit:</b> 75% = \$411.55	this Category)
		ar joint or proximal radio-hum	treatment of fracture of, in conjunction with dislocation eral joint (Galeazzi or Monteggia injury), by closed
<b>Amend</b> <b>Fee</b> 50524	(See para TN.8.119, <b>Fee:</b> \$425.10	TN.8.118 of explanatory notes to <b>Benefit:</b> 75% = \$318.85	this Category)
	of distal radio-ulna	ar joint or proximal radio-hum	treatment of fracture of, in conjunction with dislocation eral joint (Galeazzi or Monteggia injury), by reduction ataneous means (H) (Anaes.) (Assist.)
Amend Fee 50528	(See para TN.8.119, <b>Fee:</b> \$685.70	TN.8.118 of explanatory notes to <b>Benefit:</b> 75% = \$514.30	this Category)
<b>Amend</b> <b>Fee</b> 50532	growth plate (H) (.		for both), by closed reduction, for a patient with open this Category)
	Treatment of fract		or both), by open or closed reduction, with internal (Anaes.) (Assist.)
Amend Fee 50536	(See para TN.8.119, <b>Fee:</b> \$795.40	TN.8.118 of explanatory notes to <b>Benefit:</b> 75% = \$596.55	this Category)
	Olecranon, with op	pen growth plate, treatment of	fracture of, by open reduction (H) (Anaes.) (Assist.)
<b>Amend</b> <b>Fee</b> 50540	(See para TN.8.119, <b>Fee:</b> \$548.70	TN.8.118 of explanatory notes to <b>Benefit:</b> 75% = \$411.55	this Category)
	Radius, with open	growth plate, treatment of frac	cture of head or neck of, by closed reduction of (Anaes.)
<b>Amend</b> <b>Fee</b> 50544	(See para TN.8.119, <b>Fee:</b> \$274.25	TN.8.118 of explanatory notes to <b>Benefit:</b> 75% = \$205.70 85	
	-	growth plate, treatment of frac y open or percutaneous means	ture of head or neck of, by reduction with or without (H) (Anaes.) (Assist.)
<b>Amend</b> <b>Fee</b> 50548	(See para TN.8.119, <b>Fee:</b> \$548.70	TN.8.118 of explanatory notes to <b>Benefit:</b> 75% = \$411.55	this Category)
	Humerus, proxima	l, with open growth plate, trea	tment of fracture of, by closed reduction (H) (Anaes.)
Amend Fee 50552	(See para TN.8.119, <b>Fee:</b> \$473.20	TN.8.118 of explanatory notes to <b>Benefit:</b> 75% = \$354.90	this Category)
Amend			pen or closed reduction, with internal fixation, for a

Fee 50556         patient with open growth plate (H) (Anaes.) (Assist.)           50556         (See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$630.80         Benefit: 75% = \$473.10           Amend Fee         (See para TN.8.119, TN.8.118 of explanatory notes to this Category) 50560         Fee: \$493.65         Benefit: 75% = \$370.25           Treatment of fracture of shaft of humerus, by open or closed reduction, with internal or external for a patient with open growth plate (H) (Anaes.) (Assist.)           Amend Fee         (See para TN.8.119, TN.8.118 of explanatory notes to this Category)           50564         Fee: \$658.25         Benefit: 75% = \$493.70           Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction (H) (Anaes.)         Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduct or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)           Amend Fee         (See para TN.8.119, TN.8.118 of explanatory notes to this Category)           50572         Fee: \$76.05         Benefit: 75% = \$473.10           Store         Fee: \$768.00         Benefit: 75% = \$576.00           Treatment of fracture of femur, by closed reduction or traction, including application of hip spic performed), for a patient with open growth plate (Anaes.) (Assist.)           Amend Fee         (See para TN.8.119, TN.8.118 of explanatory notes to this Category)           50576         Fee: \$53.05	
(See para TN.8.119, TN.8.118 of explanatory notes to this Category)         Fee:       \$503.00       Benefit: 75% = \$473.10         Amend       Humerus, shaft of, with open growth plate, treatment of fracture of, by closed reduction (H) (An Associated et al. 19, TN.8.118 of explanatory notes to this Category)         50560       Fee:       \$493.65       Benefit: 75% = \$370.25         Treatment of fracture of shaft of humerus, by open or closed reduction, with internal or external for a patient with open growth plate (H) (Anaes.) (Assist.)         Amend       Fee:       \$658.25       Benefit: 75% = \$493.70         S0564       Fee:       \$658.25       Benefit: 75% = \$432.05         Amend       (See para TN.8.119, TN.8.118 of explanatory notes to this Category)         \$05564       Fee:       \$658.25       Benefit: 75% = \$432.05         Amend       Fee       (See para TN.8.119, TN.8.118 of explanatory notes to this Category)         \$05568       Fee:       \$576.05       Benefit: 75% = \$432.05         Amend       Fee       See para TN.8.119, TN.8.118 of explanatory notes to this Category)         \$05572       Fee:       \$576.00       Benefit: 75% = \$576.00         Fee       See para TN.8.119, TN.8.118 of explanatory notes to this Category)       \$5572         Fee       \$568.00       Benefit: 75% = \$576.00         Fee       See p	
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Fee       (See para TN.8.119, TN.8.118 of explanatory notes to this Category)         50560       Fee: \$493.65       Benefit: 75% = \$370.25         Amend       Freatment of fracture of shaft of humerus, by open or closed reduction, with internal or external for a patient with open growth plate (H) (Anaes.) (Assist.)         S0564       Fee: \$588.25       Benefit: 75% = \$493.70         Butter of the external for the external for a patient with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction (H) (Anaes.)         Amend       Fee: \$576.05       Benefit: 75% = \$432.05         Fee       (See para TN.8.119, TN.8.118 of explanatory notes to this Category)         \$50568       Fee: \$576.05       Benefit: 75% = \$432.05         Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduct or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)         Amend       Fee: \$576.00       Benefit: 75% = \$576.00         Fee: \$768.00       Benefit: 75% = \$576.00         Fee: \$638.03       Benefit: 75% = \$473.10         \$50570       Fee: \$576.00         Fee: \$630.80       Benefit: 75% = \$473.10         Fee       (See para TN.8.119, TN.8.118 of explanatory notes to this Category)         \$50570       Fee: \$658.25         Benefit: 75% = \$473.10       Ramend         Fee       (See pa	ues.)
Amend Fee 50564for a patient with open growth plate (H) (Anaes.) (Assist.)Amend Fee 50564(See para TN.8.119, TN.8.118 of explanatory notes to this Category)50564Fee: \$658.25Benefit: 75% = \$493.70Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction (H) (Anaes.)Amend Fee S0568(See para TN.8.119, TN.8.118 of explanatory notes to this Category)50568Fee: \$576.05Benefit: 75% = \$432.05Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduct or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)Amend Fee S0572Fee: \$768.00Benefit: 75% = \$576.00Treatment of fracture of femur, by closed reduction or traction, including application of hip spic performed), for a patient with open growth plate (Anaes.) (Assist.)Amend Fee S0576Gee para TN.8.119, TN.8.118 of explanatory notes to this Category)50576Fee: \$630.80Benefit: 75% = \$473.1085980Fee: \$630.80Benefit: 75% = \$473.10S0580Fee: \$658.25Benefit: 75% = \$493.70Tibia, with open growth plate, treatment of fracture of, by reduction with or without intern fixation by open or percutaneous means (H) (Anaes.) (Assist.)Amend Fee 	
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50564       Fee: \$658.25       Benefit: 75% = \$493.70         Amend       Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction (H) (Anaes.)         Amend       (See para TN.8.119, TN.8.118 of explanatory notes to this Category)         50568       Fee: \$576.05       Benefit: 75% = \$432.05         Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduct or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)         Amend       Fee         Fee       (See para TN.8.119, TN.8.118 of explanatory notes to this Category)         50572       Fee: \$768.00       Benefit: 75% = \$576.00         Treatment of fracture of femur, by closed reduction or traction, including application of hip spic performed), for a patient with open growth plate (Anaes.) (Assist.)         Amend       Fee       (See para TN.8.119, TN.8.118 of explanatory notes to this Category)         50576       Fee: \$630.80       Benefit: 75% = \$473.10       85% = \$546.10         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 (H) (Anaes.) (Assist.)         Amend       Fee: \$658.25       Benefit: 75% = \$493.70         Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.)         5058	
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Amend Fee (See para TN.8.119, TN.8.118 of explanatory notes to this Category)50576Fee: \$630.80Benefit: 75% = \$473.1085% = \$546.10Tibia, 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 (H) (Anaes.) (Assist.)Amend Fee (See para TN.8.119, TN.8.118 of explanatory notes to this Category)50580Fee: \$658.25Benefit: 75% = \$493.70Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without intern fixation by open or percutaneous means (H) (Anaes.) (Assist.)Amend Fee fee (See para TN.8.119, TN.8.118 of explanatory notes to this Category)50580Fee: \$658.25Benefit: 75% = \$493.70Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without intern fixation by open or percutaneous means (H) (Anaes.) (Assist.)Amend Fee Fee (See para TN.8.119, TN.8.118 of explanatory notes to this Category) 50584Fee: \$630.80Benefit: 75% = \$473.10Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anae (Assist.)Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anae (Assist.)	l (11
50576Fee: \$630.80Benefit: 75% = \$473.1085% = \$546.10Tibia, 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 (H) (Anaes.) (Assist.)Amend Fee 50580(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$658.25Benefit: 75% = \$493.70Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without intern fixation by open or percutaneous means (H) (Anaes.) (Assist.)Amend Fee 50584Fee: \$630.80Benefit: 75% = \$473.10Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anae (Assist.))Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anae (Assist.))	
Amend Fee 50580reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)Amend Fee: \$658.25(See para TN.8.119, TN.8.118 of explanatory notes to this Category)Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without intern fixation by open or percutaneous means (H) (Anaes.) (Assist.)Amend Fee 50584(See para TN.8.119, TN.8.118 of explanatory notes to this Category)50584Fee: \$630.80Benefit: 75% = \$473.10Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anae (Assist.))	
Amend Fee 50580(See para TN.8.119, TN.8.118 of explanatory notes to this Category)50580Fee: \$658.25Benefit: 75% = \$493.70Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without intern fixation by open or percutaneous means (H) (Anaes.) (Assist.)Amend Fee 50584See para TN.8.119, TN.8.118 of explanatory notes to this Category)50584Fee: \$630.80Benefit: 75% = \$473.10Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anae (Assist.)	
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Amend Fee 50584Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without inter- fixation by open or percutaneous means (H) (Anaes.) (Assist.)Amend Fee 50584(See para TN.8.119, TN.8.118 of explanatory notes to this Category)Fee: 50584\$630.80Benefit: 75% = \$473.10Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anae (Assist.))	
Amend       fixation by open or percutaneous means (H) (Anaes.) (Assist.)         Fee       (See para TN.8.119, TN.8.118 of explanatory notes to this Category)         50584       Fee: \$630.80       Benefit: 75% = \$473.10         Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anae (Assist.)	
Amend       Kee       (See para TN.8.119, TN.8.118 of explanatory notes to this Category)         50584       Fee: \$630.80       Benefit: 75% = \$473.10         Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anator (Assist.)       (Assist.)	al
50584       Fee: \$630.80       Benefit: 75% = \$473.10         Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anato (Assist.))	
(Assist.)	
	s.)
Amena	
Fee (See para TN.8.119, TN.8.118 of explanatory notes to this Category)	
50588         Fee: \$822.75         Benefit: 75% = \$617.10	
Treatment of fracture of shaft of femur, by open or closed reduction, with internal or external fix for a patient with open growth plate (H) (Anaes.) (Assist.)	ation,
New	
50592         Fee: \$999.15         Benefit: 75% = \$749.40	
Treatment of fracture of shaft of tibia, by open or closed reduction, including casting, for a patient open growth plate (H) (Anaes.) (Assist.)	nt with
<b>New</b> 50596 <b>Fee:</b> \$312.35 <b>Benefit:</b> 75% = \$234.30	
SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS	

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC
	Scoliosis or kyphosis, in a child, manipulation of deformity and applic general anaesthesia, in a hospital (H) (Anaes.) (Assist.)	ation of a localiser cast, under
<b>Amend</b> <b>Fee</b> 50600	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$452.30 <b>Benefit:</b> 75% = \$339.25	
	Scoliosis or kyphosis, in a child or adolescent, spinal fusion for (witho (Assist.)	out instrumentation) (H) (Anaes.)
<b>Amend</b> <b>Fee</b> 50604	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> $$1,919.75$ <b>Benefit:</b> $75\% = $1439.85$	
A	Scoliosis or kyphosis, in a child or adolescent, treatment by segmental spine, other than a service to which any of items 51011 to 51171 apply	
<b>Amend</b> <b>Fee</b> 50608	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,565.85 <b>Benefit:</b> 75% = \$2674.40	
	Scoliosis or kyphosis, in a child or adolescent, with spinal deformity, to instrumentation, utilising separate anterior and posterior approaches, or items 51011 to 51171 apply (H) (Anaes.) (Assist.)	
Amend Fee 50612	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$5,072.05 <b>Benefit:</b> 75% = \$3804.05	
	Scoliosis, in a child or adolescent, re-exploration for adjustment or reminstrumentation used for correction of spine deformity (H) (Anaes.) (A	
<b>Amend</b> <b>Fee</b> 50616	(See para TN.8.118 of explanatory notes to this Category) Fee: \$644.45 Benefit: 75% = \$483.35	
	Scoliosis, in a child or adolescent, revision of failed scoliosis surgery, osteotomy, fusion, removal of instrumentation or instrumentation, othe items 51011 to 51171 apply (H) (Anaes.) (Assist.)	
<b>Amend</b> <b>Fee</b> 50620	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,565.85 <b>Benefit:</b> 75% = \$2674.40	
	Scoliosis, in a child or adolescent, anterior correction of, with fusion a Zielke or similar) - not more than 4 levels (H) (Anaes.) (Assist.)	nd segmental fixation (Dwyer,
Amend Fee 50624	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,565.85 <b>Benefit:</b> 75% = \$2674.40	
	Scoliosis, in a child or adolescent, anterior correction of, with fusion a Zielke or similar)—more than 4 levels (H) (Anaes.) (Assist.)	nd segmental fixation (Dwyer,
Amend Fee 50628	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$4,404.75 <b>Benefit:</b> 75% = \$3303.60	
	Scoliosis or kyphosis, in a child or adolescent, requiring segmental ins spine down to and including the pelvis or sacrum, other than a service 51171 apply (H) (Anaes.) (Assist.)	
<b>Amend</b> <b>Fee</b> 50632	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,702.90 Benefit: 75% = \$2777.20	
Amend	Scoliosis, in a child or adolescent, requiring anterior decompression of resection and instrumentation in the presence of spinal cord involvementation of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	
Fee 50636	(See para TN.8.118 of explanatory notes to this Category)	

	GICAL OPERATIONS	15. ORTHOPAEDIO
	<b>Fee:</b> \$4,114.30 <b>Benefit:</b> 75% = \$3085.75	
	Scoliosis, in a child or adolescent, congenital, resection or posterior approach, other than a service to which any (Assist.)	
<b>Amend</b> F <b>ee</b> 50640	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,274.35 <b>Benefit:</b> 75% = \$1705.80	
Amend	Spine, bone graft to, for a child or adolescent, associated kyphosis or both (H) (Anaes.) (Assist.)	l with surgery for correction of scoliosis or
F <b>ee</b> 50644	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,194.40 <b>Benefit:</b> 75% = \$1645.80	
	TREATMENT OF HIP DYSPLASIA OR DISLO	OCATION IN PAEDIATRIC PATIENTS
Amend	Treatment of hip dysplasia or dislocation, for a patient u closed reduction (or both), with or without arthrography application or reapplication of a hip spica (H) (Anaes.) (	of the hip under anaesthesia, and with
Fee 50654	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$516.75 <b>Benefit:</b> 75% = \$387.60	
T8. SUR	GICAL OPERATIONS	6. RADIOFREQUENCY AND MICROWAV TISSUE ABLATIO
	Group T8. Surgical Operations	
	Subgroup 16. Radiofrequency An	d Microwave Tissue Ablation
	Unresectable primary malignant tumour of the liver, des any associated imaging services), other than a service as 50952 applies	
Amend Fee	(Anaes.)	
50950	<b>Fee:</b> \$850.20 <b>Benefit:</b> 75% = \$637.65 85% = \$76	5.50
	Unresectable primary malignant tumour of the liver, des (including any associated imaging services), if a multi-d ablation cannot be performed or is not practical because circumstances: (a) percutaneous access cannot be achieved;	isciplinary team has assessed that percutaneous
	(b) vital organs or tissues are at risk of damage from the (c) resection of one part of the liver is possible, however unresectable portion of the liver that is suitable for ablat other than a service associated with a service to which it	there is at least one primary liver tumour in an ion;
	(Anaes.)	
	(See para TN.8.120 of explanatory notes to this Category)	
Amend Fee 50952	Fee: $$850.20$ Benefit: $75\% = $637.65$ $85\% = $76$	5.50
F <b>ee</b> 50952		5.50 17. SPINAL SURGER

T8. SUF	GICAL OPERATIONS 17. SPINAL SURGERY
	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.)
<b>Fee</b> 51011	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) <b>Fee:</b> \$1,493.65 <b>Benefit:</b> 75% = \$1120.25
	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.)
<b>Fee</b> 51012	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) <b>Fee:</b> \$1,991.30 <b>Benefit:</b> 75% = \$1493.50
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 3 motion segments, not being a service associated with a service to which item 51011, 51012, 51014 or 51015 applies (Anaes.) (Assist.)
<b>Fee</b> 51013	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) <b>Fee:</b> \$2,489.20 <b>Benefit:</b> 75% = \$1866.90
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51015 applies (Anaes.) (Assist.)
<b>Fee</b> 51014	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) <b>Fee:</b> \$2,987.05 <b>Benefit:</b> 75% = \$2240.30
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, more than 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51014 applies (Anaes.) (Assist.)
<b>Fee</b> 51015	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) <b>Fee:</b> \$3,484.90 <b>Benefit:</b> 75% = \$2613.70
	Simple fixation of part of one vertebra (not motion segment) including pars interarticularis, spinous process or pedicle, or simple interspinous wiring between 2 adjacent vertebral levels, not being a service associated with:
	(a) interspinous dynamic stabilisation devices; or
	(b) a service to which item 51021, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.)
<b>Fee</b> 51020	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) <b>Fee:</b> \$796.45 <b>Benefit:</b> 75% = \$597.35
	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, one motion segment, not being a service associated with a service to which item 51020, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.)
<b>Fee</b> 51021	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) <b>Fee:</b> \$1,333.15 <b>Benefit:</b> 75% = \$999.90
	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 2 motion segments, not being a service associated with a service to which item 51020, 51021, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.)
Fee 51022	(See para TN.8.141, TN.8.143 of explanatory notes to this Category)

T8. SUF	GICAL OPERATIONS	17. SPINAL SURGERY
	<b>Fee:</b> \$1,658.30 <b>Benefit:</b> 75% = \$1243.7	75
		body screw, pedicle screw or hook instrumentation including gments, not being a service associated with a service to which 51026 applies (Anaes.) (Assist.)
<b>Fee</b> 51023	(See para TN.8.141, TN.8.143 of explanatory no <b>Fee:</b> \$1,973.45 <b>Benefit:</b> 75% = \$1480.1	
		body screw, pedicle screw or hook instrumentation including gments, not being a service associated with a service to which 51026 applies (Anaes.) (Assist.)
<b>Fee</b> 51024	(See para TN.8.141, TN.8.143 of explanatory no <b>Fee:</b> \$2,278.30 <b>Benefit:</b> 75% = \$1708.7	
		body screw, pedicle screw or hook instrumentation including egments, not being a service associated with a service to 1024 or 51026 applies (Anaes.) (Assist.)
<b>Fee</b> 51025	(See para TN.8.141, TN.8.143 of explanatory no Fee: \$2,662.90 Benefit: 75% = \$1997.2	
		body screw, pedicle screw or hook instrumentation including tion segments, not being a service associated with a service 51024 or 51025 applies (Anaes.) (Assist.)
<b>Fee</b> 51026	(See para TN.8.141, TN.8.143 of explanatory no <b>Fee:</b> \$2,915.45 <b>Benefit:</b> 75% = \$2186.0	
		graft to, one motion segment, not being a service associated 51034, 51035 or 51036 applies (Anaes.) (Assist.)
<b>Fee</b> 51031	(See para TN.8.141, TN.8.144 of explanatory no <b>Fee:</b> \$979.60 <b>Benefit:</b> 75% = \$734.70	
		graft to, 2 motion segments, not being a service associated 51034, 51035 or 51036 applies (Anaes.) (Assist.)
<b>Fee</b> 51032	(See para TN.8.141, TN.8.144 of explanatory no <b>Fee:</b> \$1,175.55 <b>Benefit:</b> 75% = \$881.70	
		graft to, 3 motion segments, not being a service associated 51034, 51035 or 51036 applies (Anaes.) (Assist.)
<b>Fee</b> 51033	(See para TN.8.141, TN.8.144 of explanatory no <b>Fee:</b> \$1,371.50 <b>Benefit:</b> 75% = \$1028.6	
		graft to, 4 to 7 motion segments, not being a service 31, 51032, 51033, 51035 or 51036 applies (Anaes.) (Assist.)
<b>Fee</b> 51034	(See para TN.8.141, TN.8.144 of explanatory no <b>Fee:</b> \$1,469.40 <b>Benefit:</b> 75% = \$1102.0	
		graft to, 8 to 11 motion segments, not being a service 31, 51032, 51033, 51034 or 51036 applies (Anaes.) (Assist.)
<b>Fee</b> 51035	(See para TN.8.141, TN.8.144 of explanatory no <b>Fee:</b> \$1,567.35 <b>Benefit:</b> 75% = \$1175.5	
Fee 51036	Spine, posterior and/or posterolateral bone	graft to, 12 or more motion segments, not being a service

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	associated with a service to which item 51031, 51032, 51033, 51	034 or 51035 applies (Anaes.) (Assist.)
	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) <b>Fee:</b> \$1,665.35 <b>Benefit:</b> 75% = \$1249.05	
	Spinal fusion, anterior column (anterior, direct lateral or posterior being a service associated with a service to which item 51042, 5 (Assist.)	
<b>Fee</b> 51041	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) <b>Fee:</b> \$1,126.55 <b>Benefit:</b> 75% = \$844.95	
	Spinal fusion, anterior column (anterior, direct lateral or posterior being a service associated with a service to which item 51041, 5 (Assist.)	
<b>Fee</b> 51042	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) <b>Fee:</b> \$1,577.20 <b>Benefit:</b> 75% = \$1182.90	
	Spinal fusion, anterior column (anterior, direct lateral or posterior being a service associated with a service to which item 51041, 5 (Assist.)	
<b>Fee</b> 51043	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) <b>Fee:</b> \$1,971.55 <b>Benefit:</b> 75% = \$1478.70	
	Spinal fusion, anterior column (anterior, direct lateral or posterior being a service associated with a service to which item 51041, 5 (Assist.)	
<b>Fee</b> 51044	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) <b>Fee:</b> \$2,140.50 <b>Benefit:</b> 75% = \$1605.40	
	Spinal fusion, anterior column (anterior, direct lateral or posterior segments, not being a service associated with a service to which applies (Anaes.) (Assist.)	
<b>Fee</b> 51045	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) <b>Fee:</b> \$2,253.15 <b>Benefit:</b> 75% = \$1689.90	
	Pedicle subtraction osteotomy, one vertebra, not being a service item 51052, 51053, 51054, 51055, 51056, 51057, 51058 or 5105	
<b>Fee</b> 51051	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$1,924.95 <b>Benefit:</b> 75% = \$1443.75	
	Pedicle subtraction osteotomy, 2 vertebrae, not being a service a item 51051, 51053, 51054, 51055, 51056, 51057, 51058 or 5105	
<b>Fee</b> 51052	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,341.20 <b>Benefit:</b> 75% = \$1755.90	
	Vertebral column resection osteotomy performed through single being a service associated with a service to which item 51051, 5 51058 or 51059 applies (Anaes.) (Assist.)	
<b>Fee</b> 51053	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,663.70 <b>Benefit:</b> 75% = \$1997.80	
<b>Fee</b> 51054	Vertebral body, piecemeal or subtotal excision of (where piecem removal of more than 50% of the vertebral body), one vertebra, r	

T8. SUF	RGICAL OPERATIONS 17. SPINAL SURGE	RY
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51055, 51056, 51057, 51058 or 51059 applies (Anat (Assist.)	es.)
	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$1,420.30 <b>Benefit:</b> 75% = \$1065.25	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 2 vertebrae, not being a service associated with:	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51056, 51057, 51058 or 51059 applies (Anat (Assist.)	es.)
<b>Fee</b> 51055	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,130.45 <b>Benefit:</b> 75% = \$1597.85	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 3 or more vertebrae, not being a service associated with:	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51057, 51058 or 51059 applies (Anat (Assist.)	es.)
<b>Fee</b> 51056	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,485.50 <b>Benefit:</b> 75% = \$1864.15	
	Vertebral body, en bloc excision of (complete spondylectomy), one vertebra, not being a service associated with:	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51058 or 51059 applies (Anato (Assist.)	es.)
<b>Fee</b> 51057	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,497.25 <b>Benefit:</b> 75% = \$1872.95	
	Vertebral body, en bloc excision of (complete spondylectomy), 2 vertebrae, not being a service associated with:	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51059 applies (Ana (Assist.)	les.)
<b>Fee</b> 51058	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,809.90 <b>Benefit:</b> 75% = \$2107.45	
	Vertebral body, en bloc excision of (complete spondylectomy), 3 or more vertebrae, not being a service associated with:	ce
	(a) anterior column fusion when at the same motion segment; or	
Fee 51059	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51058 applies (Anat	es.)

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	(Assist.)	
	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$3,433.75 <b>Benefit:</b> 75% = \$2575.35	
	Spinal fusion, anterior and posterior, including spinal instrume and/or posterolateral bone graft, and anterior column fusion, no to which item 51062, 51063, 51064, 51065 or 51066 applies (A	ot being a service associated with a service
<b>Fee</b> 51061	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$2,949.50 <b>Benefit:</b> 75% = \$2212.15	
	Spinal fusion, anterior and posterior, including spinal instrume and/or posterolateral bone graft, and anterior column fusion, no to which item 51061, 51063, 51064, 51065 or 51066 applies (A	ot being a service associated with a service
<b>Fee</b> 51062	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$3,823.25 <b>Benefit:</b> 75% = \$2867.45	
	Spinal fusion, anterior and posterior, including spinal instrume and/or posterolateral bone graft, and anterior column fusion, no to which item 51061, 51062, 51064, 51065 or 51066 applies ( <i>A</i>	ot being a service associated with a service
<b>Fee</b> 51063	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$4,630.65 <b>Benefit:</b> 75% = \$3473.00	
	Spinal fusion, anterior and posterior, including spinal instrume posterior and/or posterolateral bone graft, and anterior column with a service to which item 51061, 51062, 51063, 51065 or 5	fusion, not being a service associated
<b>Fee</b> 51064	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$5,153.55 <b>Benefit:</b> 75% = \$3865.20	
	Spinal fusion, anterior and posterior, including spinal instrume posterior and/or posterolateral bone graft, and anterior column with a service to which item 51061, 51062, 51063, 51064 or 5	fusion, not being a service associated
<b>Fee</b> 51065	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$5,699.80 <b>Benefit:</b> 75% = \$4274.85	
	Spinal fusion, anterior and posterior, including spinal instrume posterior and/or posterolateral bone graft, and anterior column a service to which item 51061, 51062, 51063, 51064 or 51065	fusion not being a service associated with
<b>Fee</b> 51066	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$6,001.25 <b>Benefit:</b> 75% = \$4500.95	
	Removal of intradural lesion, not being a service associated wi applies (Anaes.) (Assist.)	ith a service to which item 51072 or 51073
<b>Fee</b> 51071	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$2,601.30 <b>Benefit:</b> 75% = \$1951.00	
	Craniocervical junction lesion, transoral approach for, not bein which item 51071 or 51073 applies (Anaes.) (Assist.)	ag a service associated with a service to
<b>Fee</b> 51072	(See para TN.8.141 of explanatory notes to this Category) Fee: \$2,705.35 Benefit: 75% = \$2029.05	
<b>Fee</b> 51073	Removal of intramedullary tumour or arteriovenous malformat service to which item 51071 or 51072 applies (Anaes.) (Assist	

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$3,433.75 <b>Benefit:</b> 75% = \$2575.35	
	Thoracoplasty in combination with thoracic scoliosis correction—3	3 or more ribs (Anaes.) (Assist.)
<b>Fee</b> 51102	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$1,231.40 <b>Benefit:</b> 75% = \$923.55	
	Odontoid screw fixation (Anaes.) (Assist.)	
<b>Fee</b> 51103	(See para TN.8.141, TN.8.148 of explanatory notes to this Category) <b>Fee:</b> \$2,164.05 <b>Benefit:</b> 75% = \$1623.05	
	Spine, treatment of fracture, dislocation or fracture dislocation, with not including application of skull tongs or calipers as part of operat	
<b>Fee</b> 51110	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$783.80 <b>Benefit:</b> 75% = \$587.85 85% = \$699.10	
	Skull calipers or halo, insertion of, as an independent procedure (A	naes.)
<b>Fee</b> 51111	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$333.10 <b>Benefit:</b> 75% = \$249.85	
	Plaster jacket, application of, as an independent procedure (Anaes.)	)
<b>Fee</b> 51112	(See para TN.8.141 of explanatory notes to this Category)           Fee: \$225.25         Benefit: 75% = \$168.95         85% = \$191.50	
	Halo, application of, in addition to spinal fusion for scoliosis, or oth	her conditions (Anaes.)
<b>Fee</b> 51113	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$249.80 <b>Benefit:</b> 75% = \$187.35	
	Halo thoracic orthosis—application of both halo and thoracic jacke	t (Anaes.)
<b>Fee</b> 51114	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$440.95 <b>Benefit:</b> 75% = \$330.75	
	Halo femoral traction, as an independent procedure (Anaes.)	
<b>Fee</b> 51115	(See para TN.8.141 of explanatory notes to this Category)           Fee: \$440.95         Benefit: 75% = \$330.75         85% = \$374.85	
	Bone graft, harvesting of autogenous graft, via separate incision or conjunction with spinal fusion, other than for the purposes of bone thoracic, lumbar or sacral spine (Anaes.)	<b>11</b>
<b>Fee</b> 51120	(See para TN.8.141 of explanatory notes to this Category) Fee: \$245.05 Benefit: 75% = \$183.80	
	Lumbar artificial intervertebral total disc replacement, at one motio disc and marginal osteophytes:	n segment only, including removal of
	(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	
Fee 51130	(b) not being a service associated with a service to which item 5101	11, 51012, 51013, 51014 or 51015

T8. SUF	JRGICAL OPERATIONS 17. SPIN	NAL SURGERY
	applies (Anaes.) (Assist.)	
	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$1,866.35 <b>Benefit:</b> 75% = \$1399.80	
	Cervical artificial intervertebral total disc replacement, at one motion segment only, inc of disc and marginal osteophytes, for a patient who:	luding removal
	(a) has not had prior spinal surgery at the same cervical level; and	
	(b) is skeletally mature; and	
	(c) has symptomatic degenerative disc disease with radiculopathy; and	
	(d) does not have vertebral osteoporosis; and	
	(e) has failed conservative therapy (Anaes.) (Assist.)	
<b>Fee</b> 51131	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$1,126.55 <b>Benefit:</b> 75% = \$844.95	
	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrument motion segments, not being a service associated with a service to which item 51141 app (Assist.)	
<b>Fee</b> 51140	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$460.40 <b>Benefit:</b> 75% = \$345.30	
	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumer 3 motion segments, not being a service associated with a service to which item 51140 ap (Assist.)	
<b>Fee</b> 51141	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$851.70 <b>Benefit:</b> 75% = \$638.80	
	Wound debridement or excision for post operative infection or haematoma following sp (Anaes.) (Assist.)	inal surgery
<b>Fee</b> 51145	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$460.40 <b>Benefit:</b> 75% = \$345.30	
	Coccyx, excision of (Anaes.) (Assist.)	
<b>Fee</b> 51150	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$463.50 <b>Benefit:</b> 75% = \$347.65	
	Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service 51165 applies (Anaes.) (Assist.)	to which item
<b>Fee</b> 51160	(See para TN.8.141, TN.8.149 of explanatory notes to this Category) <b>Fee:</b> \$1,196.60 <b>Benefit:</b> 75% = \$897.45	
	Anterior exposure of thoracic or lumbar spine, more than one motion segment, not being which item 51160 applies (Anaes.) (Assist.)	g a service to
<b>Fee</b> 51165	(See para TN.8.141, TN.8.149 of explanatory notes to this Category) <b>Fee:</b> \$1,508.75 <b>Benefit:</b> 75% = \$1131.60	
<b>Fee</b> 51170	Syringomyelia or hydromyelia, craniotomy for, with or without duraplasty, intradural diplugging of obex or local cerebrospinal fluid shunt (Anaes.) (Assist.)	issection,

T8. SUR	GICAL OPERATIONS 17. SPINAL SURGERY
	(See para TN.8.141 of explanatory notes to this Category)Fee: $$2,273.15$ Benefit: $75\% = $1704.90$
	Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid shunt (for example, syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal shunt) (Anaes.) (Assist.)
<b>Fee</b> 51171	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$954.60 <b>Benefit:</b> 75% = \$715.95
T9. ASS	ISTANCE AT OPERATIONS
	Group T9. Assistance At Operations
A	Assistance at any operation identified by the word "Assist." for which the fee does not exceed \$580.95 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed \$580.95
<b>Amend</b> <b>Fee</b> 51300	(See para TN.9.2, TN.9.1 of explanatory notes to this Category)         Fee: \$89.80       Benefit: 75% = \$67.35         85% = \$76.35
	Assistance at any operation identified by the word "Assist." for which the fee exceeds \$580.95 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds \$580.95
<b>Amend</b> 51303	(See para TN.9.1, TN.9.3 of explanatory notes to this Category) <b>Derived Fee:</b> one fifth of the established fee for the operation or combination of operations
	Assistance at a birth involving Caesarean section
<b>Fee</b> 51306	(See para TN.9.1 of explanatory notes to this Category) <b>Fee:</b> \$129.70 <b>Benefit:</b> 75% = \$97.30 85% = \$110.25
	Assistance at a series or combination of operations that include "(Assist.)" and assistance at a birth involving Caesarean section
51309	(See para TN.9.1, TN.9.4 of explanatory notes to this Category) <b>Derived Fee:</b> one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627
51312	(See para TN.4.11, TN.9.1 of explanatory notes to this Category) <b>Derived Fee:</b> one fifth of the established fee for the procedure or combination of procedures
	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779
<b>Fee</b> 51315	(See para TN.9.1 of explanatory notes to this Category)         Fee: \$283.45       Benefit: 75% = \$212.60       85% = \$240.95
	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
<b>Fee</b> 51318	- 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

T9. ASS	ISTANCE AT OP	ERATIONS
	· •	IN.9.1 of explanatory notes to this Category)
	Fee: \$187.05	<b>Benefit:</b> 75% = \$140.30 85% = \$159.00
ANAES ONLY P PERFOR	AYABLE FOR A	ARE BENEFITS ARE
		tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service
		Subgroup 1. Head
	tissue, muscles, s	F MANAGEMENT OF ANAESTHESIA for procedures on the skin, subcutaneous valivary glands or superficial vessels of the head including biopsy, not being a service to the min this Subgroup applies (5 basic units)
20100	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units)
20102	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units)
20104	<b>Fee:</b> \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF	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: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units)
20124	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
		F MANAGEMENT OF ANAESTHESIA for procedures on eye, not being a service to em in this Group applies (5 basic units)
20140	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
20140		F MANAGEMENT OF ANAESTHESIA for lens surgery (5 basic units)
	<b>Fee:</b> \$103.00	Benefit: 75% = \$77.25 85% = \$87.55
20142	Extended Medic	care Safety Net Cap: \$82.40
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units)
20143	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for corneal transplant (7 basic units)
20144	Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15 85% = \$122.60
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for vitrectomy (7 basic units)
20145	Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15 85% = \$122.60
		F MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units)
20146	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55

LATIVE VALUE	
	ARE BENEFITS ARE NAESTHESIA
RMED IN ASSOC	CIATION WITH AN
	1. HEAD
INITIATION O	F MANAGEMENT OF ANAESTHESIA for squint repair (6 basic units)
Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10
INITIATION O	F MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units)
Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	management of anaesthesia for intranasal or accessory sinuses, not being a service to em in this Subgroup applies (6 basic units)
Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	management of anaesthesia for intranasal surgery for malignancy or for intranasal units)
Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15 85% = \$122.60
	F MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and es (4 basic units)
Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	F MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, not o which another item in this Subgroup applies (6 basic units)
Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10
INITIATION O	F MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units)
Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15 85% = \$122.60
INITIATION O basic units)	F MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9
Fee: \$185.40	<b>Benefit:</b> 75% = \$139.05 85% = \$157.60
INITIATION O	F MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units)
Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50 85% = \$175.10
	F MANAGEMENT OF ANAESTHESIA for procedures on facial bones, not being a another item in this Subgroup applies (5 basic units)
Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	F MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones athism and extensive facial bone reconstruction) (10 basic units)
Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50 85% = \$175.10
	F MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service r item in this Subgroup applies (15 basic units)
Fee: \$309.00	<b>Benefit:</b> 75% = \$231.75 85% = \$262.65
INITIATION O	F MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units)
1	
	HESIA - MEDICA A ABLE FOR A RED IN ASSOC E SERVICE          INITIATION O         Fee: \$123.60         INITIATION O         Fee: \$82.40         Initiation of the which another it         Fee: \$123.60         Initiation of the which another it         Fee: \$123.60         Initiation of the ablation (7 basic         Fee: \$144.20         INITIATION O         accessory sinuse         Fee: \$123.60         INITIATION O         accessory sinuse         Fee: \$123.60         INITIATION O         being a service t         Fee: \$123.60         INITIATION O         being a service t         Fee: \$123.60         INITIATION O         being a service t         Fee: \$144.20         INITIATION O         basic units)         Fee: \$185.40         INITIATION O         service to which         Fee: \$103.00         INITIATION O         (including progr         Fee: \$206.00         INITIATION O         (including progr         Fee: \$309.00

	LATIVE VALUE G	
-	THESIA - MEDICA AYABLE FOR AN	ARE BENEFITS ARE VAESTHESIA
PERFO	RMED IN ASSOCI	IATION WITH AN
ELIGIB		1. HEAD
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units)
20214	Fee: \$185.40	<b>Benefit:</b> 75% = \$139.05 85% = \$157.60
		<sup>7</sup> MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including ms or arterio-venous abnormalities (20 basic units)
20216	Fee: \$412.00	<b>Benefit:</b> 75% = \$309.00 85% = \$350.20
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic
20220	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50 85% = \$175.10
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic
20222	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units)
20225	Fee: \$247.20	<b>Benefit:</b> 75% = \$185.40 85% = \$210.15
		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery d or face (12 basic units)
20230	(See para TN.10.28 <b>Fee:</b> \$247.20	B of explanatory notes to this Category) Benefit: $75\% = $185.40$ $85\% = $210.15$
T10. RE ANAES ONLY F PERFO	Fee: \$247.20	Benefit: 75% = \$185.40 85% = \$210.15 GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN
T10. RE ANAES ONLY F PERFO	Fee: \$247.20 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Rela	Benefit: 75% = \$185.40 85% = \$210.15 GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN
T10. RE ANAES ONLY F PERFO	Fee: \$247.20 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Rela	Benefit: 75% = \$185.40 85% = \$210.15 SUIDE FOR ARE BENEFITS ARE VAESTHESIA IATION WITH AN 2. NECK tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
T10. RE ANAES ONLY F PERFO	Fee: \$247.20	Benefit: 75% = \$185.40 85% = \$210.15 GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 2. NECK tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service
T10. RE ANAES ONLY F PERFO ELIGIBI	Fee: \$247.20	Benefit: 75% = \$185.40 85% = \$210.15 GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 2. NECK tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 2. Neck TMANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous
T10. RE ANAES ONLY F PERFO	Fee: \$247.20         ELATIVE VALUE G         THESIA - MEDICA         PAYABLE FOR AN         RMED IN ASSOCI         LE SERVICE         Group T10. Relat         Anaesthesia Per         INITIATION OF         tissue of the neck         Fee: \$103.00         INITIATION OF	Benefit: 75% = \$185.40       85% = \$210.15         GUIDE FOR       ARE BENEFITS ARE         NAESTHESIA       ATION WITH AN         2. NECK       tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         formed In Association With An Eligible Service       Subgroup 2. Neck         Subgroup 2. Neck       MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous not being a service to which another item in this Subgroup applies (5 basic units)
T10. RE ANAES ONLY F PERFO ELIGIBI	Fee: \$247.20 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Relat Anaesthesia Per INITIATION OF tissue of the neck Fee: \$103.00 INITIATION OF large abscess, cel	Benefit: 75% = \$185.40 85% = \$210.15 SUIDE FOR ARE BENEFITS ARE VAESTHESIA IATION WITH AN 2. NECK tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 2. Neck TMANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous in ot being a service to which another item in this Subgroup applies (5 basic units) Benefit: 75% = \$77.25 85% = \$87.55 TMANAGEMENT OF ANAESTHESIA for incision and drainage of large haematoma,
T10. RE ANAES ONLY F PERFO ELIGIBI	Fee: \$247.20         ELATIVE VALUE G         THESIA - MEDICA         PAYABLE FOR AN         RMED IN ASSOCI         LE SERVICE         Group T10. Relat         Anaesthesia Per         INITIATION OF         tissue of the neck         Fee: \$103.00         INITIATION OF         large abscess, cel         basic units)         Fee: \$309.00         INITIATION OF         trachea, lymphati	Benefit: 75% = \$185.40 85% = \$210.15 GUIDE FOR ARE BENEFITS ARE VAESTHESIA IATION WITH AN 2. NECK tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 2. Neck TMANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous not being a service to which another item in this Subgroup applies (5 basic units) Benefit: 75% = \$77.25 85% = \$87.55 TMANAGEMENT OF ANAESTHESIA for incision and drainage of large haematoma, lulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15

T10. RELATIVE VALUE GUIDE FOR	
<b>ANAESTHESIA - MEDICARE BENEFITS ARE</b>	5
ONLY PAYABLE FOR ANAESTHESIA	
PERFORMED IN ASSOCIATION WITH AN	
ELIGIBLE SERVICE	

2. NECK

	INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units)
20321	<b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose and mouth) (8 basic units)
20330	<b>Fee:</b> \$164.80 <b>Benefit:</b> 75% = \$123.60 85% = \$140.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major vessels of neck, not being a service to which another item in this Subgroup applies (10 basic units)
20350	<b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5 basic units)
20352	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the neck (12 basic units)
	(See para TN.10.28 of explanatory notes to this Category)
ANAES ONLY P	Fee: \$247.20       Benefit: 75% = \$185.40       85% = \$210.15         ELATIVE VALUE GUIDE FOR       THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         PMED IN ASSOCIATION WITH AN
T10. RE ANAES ONLY P PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 3. THORAX
T10. RE ANAES ONLY P PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN
T10. RE ANAES ONLY P PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 3. THORAX Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
T10. RE ANAES ONLY P PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 3. THORAX 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 P PERFO	ELATIVE VALUE GUIDE FOR         THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 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
T10. RE ANAES ONLY P PERFO ELIGIBI	ELATIVE VALUE GUIDE FOR         THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 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)
T10. RE ANAES ONLY P PERFO ELIGIBI	ELATIVE VALUE GUIDE FOR         THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 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)         Fee: \$61.80       Benefit: 75% = \$46.35       85% = \$52.55         INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a
T10. RE ANAES ONLY P PERFO ELIGIBI	ELATIVE VALUE GUIDE FOR         THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 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)         Fee: \$61.80       Benefit: 75% = \$46.35       85% = \$52.55         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)
T10. RE ANAES ONLY P PERFO ELIGIBI	ELATIVE VALUE GUIDE FOR         THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 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)         Fee: \$61.80       Benefit: 75% = \$46.35       85% = \$52.55         INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units)         Fee: \$82.40       Benefit: 75% = \$61.80       85% = \$70.05         INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5

ANAES ONLY F PERFO	PAYABLE FOR A	ARE BENEFITS ARE
	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units)
20404	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10
		F MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breast eous flaps (8 basic units)
20405	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60 85% = \$140.10
		F MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on rnal mammary node dissection (13 basic units)
20406	Fee: \$267.80	<b>Benefit:</b> 75% = \$200.85 85% = \$227.65
	INITIATION O basic units)	F MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (4
20410	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
		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: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55

INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the sternum (4 basic units) 20440 Fee: \$82.40 **Benefit:** 75% = \$61.80 85% = \$70.05

	ANAGEMENT OF ANAESTHESIA for procedures on clavicle, scapula or sternum which another item in this Subgroup applies (5 basic units)
<b>Fee:</b> \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55

20.00			
	INITIATION OF N sternum (6 basic ur		AESTHESIA for radical surgery on clavicle, scapula or
20452	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70	85% = \$105.10
		ANAGEMENT OF ANA	AESTHESIA for partial rib resection, not being a service to (6 basic units)
20470	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70	85% = \$105.10

INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units)

20472	<b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic units)
20474	(See para TN.10.22 of explanatory notes to this Category) <b>Fee:</b> \$267.80 <b>Benefit:</b> 75% = \$200.85 85% = \$227.65
20475	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery

ONLY F	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN	
-	LE SERVICE	3. THORAX
	involving the anterior or posterior thorax (10 basic units)	
	(See para TN.10.28 of explanatory notes to this Category) <b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10	
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE	4. INTRATHORACIC
	Group T10. Relative Value Guide For Anaesthesia - Medicare Be Anaesthesia Performed In Association With An Eligible Service	
	Subgroup 4. Intrathoracic	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open basic units)	procedures on the oesophagus (15
20500	<b>Fee:</b> \$309.00 <b>Benefit:</b> 75% = \$231.75 85% = \$262.65	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for all clo oesophagoscopy or bronchoscopy), not being a service to which and basic units)	
20520	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for needl	e biopsy of pleura (4 basic units)
20522	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pneur	mocentesis (4 basic units)
20524	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for thora	coscopy (10 basic units)
20526	<b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for media	astinoscopy (8 basic units)
20528	<b>Fee:</b> \$164.80 <b>Benefit:</b> 75% = \$123.60 85% = \$140.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for thorac pleura, diaphragm, or mediastinum, not being a service to which an (13 basic units)	
20540	<b>Fee:</b> \$267.80 <b>Benefit:</b> 75% = \$200.85 85% = \$227.65	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulme	onary decortication (15 basic units)
20542	<b>Fee:</b> \$309.00 <b>Benefit:</b> 75% = \$231.75 85% = \$262.65	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulme (15 basic units)	onary resection with thoracoplasty

T10. RELATIVE VALUE GUIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
ONLY PAYABLE FOR ANAESTHESIA
PERFORMED IN ASSOCIATION WITH AN
ELIGIBLE SERVICE
1

# 4. INTRATHORACIC

	INITIATION OF MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea
	and bronchi (15 basic units)
20548	Fee: \$309.00         Benefit: 75% = \$231.75         85% = \$262.65
	Initiation of the management of anaesthesia for:
	(a) open procedures on the heart, pericardium or great vessels of the chest; or
	(b) percutaneous insertion of a valvular prosthesis (20 basic units)
20560	<b>Fee:</b> \$412.00 <b>Benefit:</b> 75% = \$309.00 85% = \$350.20
ANAES ONLY F PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 5. SPINE AND SPINAL CORD
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 5. Spine And Spinal Cord
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord, not being a service to which another item in this Subgroup applies (for myelography and discography see Items 21908 and 21914) (10 basic units)
20600	<b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the patient in the sitting position (13 basic units)
20604	<b>Fee:</b> \$267.80 <b>Benefit:</b> 75% = \$200.85 85% = \$227.65
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord, not being a service to which another item in this Subgroup applies (10 basic units)
20620	<b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic units)
20622	<b>Fee:</b> \$267.80 <b>Benefit:</b> 75% = \$200.85 85% = \$227.65
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures in lumbar region, not being a service to which another item in this Subgroup applies (8 basic units)
20630	<b>Fee:</b> \$164.80 <b>Benefit:</b> 75% = \$123.60 85% = \$140.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units)
20632	<b>Fee:</b> \$144.20 <b>Benefit:</b> 75% = \$108.15 85% = \$122.60
20634	INITIATION OF MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units)

T10. RELATIVE VALUE GUIDE FOR
THE RELATIVE VALUE GOIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
ONLY PAYABLE FOR ANAESTHESIA
PERFORMED IN ASSOCIATION WITH AN
ELIGIBLE SERVICE

5. SPINE AND SPINAL CORD

	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50 85% = \$175.10
	INITIATION OI procedures (13 b	F MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord pasic units)
20670	(See para TN.10.2 <b>Fee:</b> \$267.80	3 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$200.85 85% = \$227.65
		F MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in eatre of a hospital (3 basic units)
20680	Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35 85% = \$52.55
		F MANAGEMENT OF ANAESTHESIA for percutaneous spinal procedures, not being th another item in this Subgroup applies (5 basic units)
20690	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
PERFO	PAYABLE FOR A RMED IN ASSOC LE SERVICE	NAESTHESIA SIATION WITH AN 6. UPPER ABDOMEN
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service
		Subgroup 6. Upper Abdomen
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er anterior abdominal wall, not being a service to which another item in this Subgroup
20700	tissue of the upp	F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er anterior abdominal wall, not being a service to which another item in this Subgroup
20700	tissue of the upp applies (3 basic <b>Fee:</b> \$61.80	F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er anterior abdominal wall, not being a service to which another item in this Subgroup units)
20700	tissue of the upp applies (3 basic <b>Fee:</b> \$61.80	F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er anterior abdominal wall, not being a service to which another item in this Subgroup units) Benefit: 75% = \$46.35 85% = \$52.55
	tissue of the upp applies (3 basic to Fee: \$61.80 INITIATION OF Fee: \$82.40 INITIATION OF	F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er anterior abdominal wall, not being a service to which another item in this Subgroup units) Benefit: 75% = \$46.35 85% = \$52.55 F MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 F MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, ia of the upper abdominal wall, not being a service to which another item in this
20702	tissue of the upp applies (3 basic to Fee: \$61.80 INITIATION OF Fee: \$82.40 INITIATION OF tendons and fasc	F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er anterior abdominal wall, not being a service to which another item in this Subgroup units) Benefit: 75% = \$46.35 85% = \$52.55 F MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 F MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, ia of the upper abdominal wall, not being a service to which another item in this
	tissue of the upp applies (3 basic to Fee: \$61.80 INITIATION OF Fee: \$82.40 INITIATION OF tendons and fasc Subgroup applie Fee: \$82.40 INITIATION OF	F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er anterior abdominal wall, not being a service to which another item in this Subgroup units) Benefit: 75% = \$46.35 85% = \$52.55 F MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 F MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, ia of the upper abdominal wall, not being a service to which another item in this s (4 basic units)
20702	tissue of the upp applies (3 basic to Fee: \$61.80 INITIATION OF Fee: \$82.40 INITIATION OF tendons and fasc Subgroup applie Fee: \$82.40 INITIATION OF involving the an	F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er anterior abdominal wall, not being a service to which another item in this Subgroup units) Benefit: 75% = \$46.35 85% = \$52.55 F MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 F MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tia of the upper abdominal wall, not being a service to which another item in this s (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
20702 20703	tissue of the upp applies (3 basic to Fee: \$61.80 INITIATION OF Fee: \$82.40 INITIATION OF tendons and fasc Subgroup applie Fee: \$82.40 INITIATION OF involving the an (See para TN.10.2 Fee: \$206.00 Initiation of the to	F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er anterior abdominal wall, not being a service to which another item in this Subgroup units) Benefit: 75% = \$46.35 85% = \$52.55 F MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 F MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tia of the upper abdominal wall, not being a service to which another item in this s (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery terior or posterior upper abdomen (10 basic units) 8 of explanatory notes to this Category)

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

## 6. UPPER ABDOMEN

	-	
	Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15 85% = \$122.60
		<sup>5</sup> MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er posterior abdominal wall, not being a service to which another item in this Subgroup units)
20730	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF procedures (5 bas	F MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic sic units)
20740	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	(a) upper gastroir	nanagement of anaesthesia for either or both of the following: nestinal endoscopic procedures in association with acute gastrointestinal haemorrhage; etrograde cholangiopancreatography (7 basic units)
20745	Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15 85% = \$122.60
		nanagement of anaesthesia for hernia repairs to the upper abdominal wall, other than a another item in this Subgroup applies. (5 basic units)
20750	(See para TN.10.27 <b>Fee:</b> \$103.00	7 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF dehiscence (6 bas	F MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound sic units)
20752	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic
20754	Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15 85% = \$122.60
	INITIATION OF hernia (9 basic ur	MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic nits)
20756	Fee: \$185.40	<b>Benefit:</b> 75% = \$139.05 85% = \$157.60
	INITIATION OF blood vessels (15	MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal basic units)
20770	Fee: \$309.00	<b>Benefit:</b> 75% = \$231.75 85% = \$262.65
	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: \$164.80	<b>Benefit:</b> 75% = \$123.60 85% = \$140.10
	Initiation of the n obesity (10 basic	nanagement of anaesthesia for bariatric surgery in a patient with clinically severe units)

T10. RELATIVE VALUE GUIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
ONLY PAYABLE FOR ANAESTHESIA
PERFORMED IN ASSOCIATION WITH AN
ELIGIBLE SERVICE

6.	UPPER	ABDOMEN
υ.		

ELIGIDI	- SERVICE 6. OFFER ADDOME
	(See para TN.8.29 of explanatory notes to this Category)Fee: $$206.00$ Benefit: $75\% = $154.50$ $85\% = $175.10$
	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units)
20792	<b>Fee:</b> \$267.80 <b>Benefit:</b> 75% = \$200.85 85% = \$227.65
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (1 basic units)
20793	<b>Fee:</b> \$309.00 <b>Benefit:</b> 75% = \$231.75 85% = \$262.65
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic units)
20794	<b>Fee:</b> \$247.20 <b>Benefit:</b> 75% = \$185.40 85% = \$210.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the upper abdomen (10 basic units)
20798	<b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra- abdominal organ in the upper abdomen (6 basic units)
ANAES ONLY F	Fee: \$123.60       Benefit: 75% = \$92.70       85% = \$105.10         LATIVE VALUE GUIDE FOR       FILE       FILE       FILE         THESIA - MEDICARE BENEFITS ARE       AYABLE FOR ANAESTHESIA       FILE       FILE         MEDICARE DEVICE       ANAESTHESIA       FILE       FILE       FILE
T10. RE ANAES ONLY F PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN .E SERVICE 7. LOWER ABDOME Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
T10. RE ANAES ONLY F PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 7. LOWER ABDOME 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	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN .E SERVICE 7. LOWER ABDOME Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
T10. RE ANAES ONLY F PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 7. LOWER ABDOME 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 ELIGIBI	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 7. LOWER ABDOME 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
T10. RE ANAES ONLY F PERFO ELIGIBI	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 7. LOWER ABDOME 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)
T10. RE ANAES ONLY F PERFO ELIGIBI	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN E SERVICE 7. LOWER ABDOME 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) Fee: \$61.80 Benefit: 75% = \$46.35 85% = \$52.55 INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic
T10. RE ANAES ONLY F PERFO	LATIVE VALUE GUIDE FOR         THESIA - MEDICARE BENEFITS ARE         AYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         E SERVICE         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)         Fee: \$61.80       Benefit: 75% = \$46.35       85% = \$52.55         INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units)
T10. RE ANAES ONLY F PERFO ELIGIBI	LATIVE VALUE GUIDE FOR ITHESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN .E SERVICE       7. LOWER ABDOME         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service       7. LOWER ABDOME         INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units)       Fee: \$61.80         Fee: \$61.80       Benefit: 75% = \$46.35       85% = \$52.55         INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units)       Fee: \$103.00         Fee: \$103.00       Benefit: 75% = \$77.25       85% = \$87.55         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

T10. RELATIVE VALUE GUIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
ONLY PAYABLE FOR ANAESTHESIA
PERFORMED IN ASSOCIATION WITH AN
ELIGIBLE SERVICE

7. LOWER ABDOMEN

LEIOID	
	involving the anterior or posterior lower abdomen (10 basic units)
	(See para TN.10.28 of explanatory notes to this Category)
	Fee:         \$206.00         Benefit:         75% = \$154.50         85% = \$175.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units)
20806	<b>Fee:</b> \$144.20 <b>Benefit:</b> 75% = \$108.15 85% = \$122.60
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures (4 basic units)
20810	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to urinary tract (6 basic units)
20815	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units)
20820	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for hernia repairs in lower abdomen, not being a service to which another item in this Subgroup applies (4 basic units)
20830	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units)
20832	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	Initiation of the management of anaesthesia for all open procedures within the lower abdominal peritoneal cavity, including appendicectomy, not being a service to which another item in this Subgroup applies (6 basic units)
20840	(See para TN.10.27 of explanatory notes to this Category) <b>Fee:</b> $$123.60$ <b>Benefit:</b> $75\% = $92.70$ $85\% = $105.10$
20840	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bowel resection, including laparoscopic bowel resection not being a service to which another item in this Subgroup applies (8 basic units)
20841	<b>Fee:</b> \$164.80 <b>Benefit:</b> 75% = \$123.60 85% = \$140.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units)
20842	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units)
20844	<b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10
20845	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units)

## T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

7. LOWER ABDOMEN

			I. LOWER ADDOMEN	
	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10	
	INITIATION OF	MANAGEMENT OF ANA	ESTHESIA for radical hysterectomy (10 basic units)	
20846	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10	
	INITIATION OF	MANAGEMENT OF ANA	ESTHESIA for ovarian malignancy (10 basic units)	
20847	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10	
	INITIATION OF	MANAGEMENT OF ANA	ESTHESIA for pelvic exenteration (10 basic units)	
20848	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10	
	INITIATION OF	MANAGEMENT OF ANA	ESTHESIA for Caesarean section (12 basic units)	
20850	<b>Fee:</b> \$247.20	<b>Benefit:</b> 75% = \$185.40	85% = \$210.15	
		MANAGEMENT OF ANA f birth (15 basic units)	ESTHESIA for Caesarean hysterectomy or hysterectomy	
20855	Fee: \$309.00	<b>Benefit:</b> 75% = \$231.75	85% = \$262.65	
		ng those on the urinary tract	ESTHESIA for extraperitoneal procedures in lower , not being a service to which another item in this Subgroup	
20860	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70	85% = \$105.10	
	INITIATION OF ureter (7 basic un		ESTHESIA for renal procedures, including upper 1/3 of	
20862	Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15	85% = \$122.60	
	INITIATION OF	MANAGEMENT OF ANA	ESTHESIA for nephrectomy (10 basic units)	
20863	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10	
	INITIATION OF	MANAGEMENT OF ANA	ESTHESIA for total cystectomy (10 basic units)	
20864	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10	
	INITIATION OF	MANAGEMENT OF ANA	ESTHESIA for adrenalectomy (10 basic units)	
20866	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units)			
20867	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10	
	INITIATION OF (10 basic units)	MANAGEMENT OF ANA	ESTHESIA for renal transplantation (donor or recipient)	
20868	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10	
			ESTHESIA for procedures on major lower abdominal item in this subgroup applies (15 basic units)	
20880	Fee: \$309.00	<b>Benefit:</b> 75% = \$231.75	85% = \$262.65	

	PAYABLE FOR A	ARE BENEFITS ARE NAESTHESIA		
	RMED IN ASSOC LE SERVICE	CIATION WITH AN 7. LOWER A	BDOMEN	
_		F MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 b		
20882	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50 85% = \$175.10		
	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion	(5 basic	
20884	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra- abdominal organ in the lower abdomen (6 basic units)			
20886	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10		
PERFO		SIATION WITH AN 8. P	ERINEUM	
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable rformed In Association With An Eligible Service	For	
		Subgroup 8. Perineum		
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcut neum not being a service to which another item in this Subgroup applies (3 ba		
20900	Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35 85% = \$52.55		
		management of anaesthesia for anorectal procedures (including surgical omy, but not banding of haemorrhoids) (4 basic units)		
20902	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05		
	INITIATION O	E MANACEMENT OF ANAESTHESIA for a distance in a loss in a	iding	
		F MANAGEMENT OF ANAESTHESIA for radical perineal procedures incluprostatectomy or radical vulvectomy (7 basic units)	uunig	
20904			lang	
20904	radical perineal prineal perineal perineal perine p	prostatectomy or radical vulvectomy (7 basic units)		
	radical perineal p Fee: \$144.20 INITIATION Of involving the pe	prostatectomy or radical vulvectomy (7 basic units) <b>Benefit:</b> 75% = \$108.15 85% = \$122.60 F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap su		
	radical perineal p <b>Fee:</b> \$144.20 INITIATION OF involving the pe (See para TN.10.2 <b>Fee:</b> \$206.00	prostatectomy or radical vulvectomy (7 basic units) <b>Benefit:</b> 75% = \$108.15 85% = \$122.60 F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap su rineum (10 basic units) 8 of explanatory notes to this Category)		
20904 20905 20906	radical perineal p <b>Fee:</b> \$144.20 INITIATION OF involving the pe (See para TN.10.2 <b>Fee:</b> \$206.00	prostatectomy or radical vulvectomy (7 basic units) <b>Benefit:</b> 75% = \$108.15 85% = \$122.60 F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap su rineum (10 basic units) 8 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$154.50 85% = \$175.10		
20905	radical perineal p Fee: \$144.20 INITIATION OD involving the period (See para TN.10.2) Fee: \$206.00 INITIATION OD Fee: \$82.40 INITIATION OD	prostatectomy or radical vulvectomy (7 basic units) Benefit: 75% = \$108.15 85% = \$122.60 F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap su rineum (10 basic units) 8 of explanatory notes to this Category) Benefit: 75% = \$154.50 85% = \$175.10 F MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units)	ing	
20905	radical perineal p Fee: \$144.20 INITIATION OD involving the period (See para TN.10.2) Fee: \$206.00 INITIATION OD Fee: \$82.40 INITIATION OD	prostatectomy or radical vulvectomy (7 basic units) Benefit: 75% = \$108.15 85% = \$122.60 F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surineum (10 basic units) 8 of explanatory notes to this Category) Benefit: 75% = \$154.50 85% = \$175.10 F MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 F MANAGEMENT OF ANAESTHESIA for transurethral procedures (include	ing	

T10. RE	LATIVE VALUE GUIDE FOR		
	THESIA - MEDICARE BENEFITS AYABLE FOR ANAESTHESIA	ARE	
PERFO	RMED IN ASSOCIATION WITH A	AN .	8. PERINEUM
ELIGIBL		a unita)	8. PERINEUM
	including laser procedures (5 basic		
	(See para TN.10.29 of explanatory note Fee: \$103.00 Benefit: 75%	tes to this Category) p = \$77.25  85% = \$87.55	
	INITIATION OF MANAGEMEN tumour(s) (5 basic units)	T OF ANAESTHESIA for transurethral resection of	of bladder
20912	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75%	p = \$77.25  85% = \$87.55	
	INITIATION OF MANAGEMEN <sup>T</sup> units)	T OF ANAESTHESIA for transurethral resection of	of prostate (7 basic
20914	<b>Fee:</b> \$144.20 <b>Benefit:</b> 75%	b = \$108.15 $85% = $122.60$	
	INITIATION OF MANAGEMEN basic units)	T OF ANAESTHESIA for bleeding post-transuret	hral resection (7
20916	<b>Fee:</b> \$144.20 <b>Benefit:</b> 75%	b = \$108.15 $85% = $122.60$	
	Initiation of management of anaest which another item in this Subgrou	thesia for procedures on external genitalia, not bein up applies. (4 basic units)	g a service to
20920	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75%	b = \$61.80  85% = \$70.05	
	INITIATION OF MANAGEMEN unilateral or bilateral (4 basic units	TT OF ANAESTHESIA for procedures on undescer s)	nded testis,
20924	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75%	p = \$61.80  85% = \$70.05	
	INITIATION OF MANAGEMEN <sup>7</sup> basic units)	T OF ANAESTHESIA for radical orchidectomy, in	nguinal approach (4
20926	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75%	b = \$61.80  85% = \$70.05	
	INITIATION OF MANAGEMEN (6 basic units)	T OF ANAESTHESIA for radical orchidectomy, a	bdominal approach
20928	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75%	p = \$92.70  85% = \$105.10	
	INITIATION OF MANAGEMEN	T OF ANAESTHESIA for orchiopexy, unilateral of	or bilateral (4 basic
20930	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75%	b = \$61.80  85% = \$70.05	
	INITIATION OF MANAGEMEN	T OF ANAESTHESIA for complete amputation of	f penis (4 basic
20932	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75%	b = \$61.80  85% = \$70.05	
	INITIATION OF MANAGEMEN bilateral inguinal lymphadenectom	TT OF ANAESTHESIA for complete amputation of ny (6 basic units)	f penis with
20934	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75%	b = \$92.70  85% = \$105.10	
20936	INITIATION OF MANAGEMEN bilateral inguinal and iliac lymphac	T OF ANAESTHESIA for complete amputation of denectomy (8 basic units)	f penis with

## T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60 85% = \$140.10
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic
20938	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
		MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures of vagina, cervix or endometrium), not being a service to which another item in this (4 basic units)
20940	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
		MANAGEMENT OF ANAESTHESIA for vaginal procedures including repair inary incontinence procedures (perineal) (5 basic units)
20942	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF (4 basic units)	MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services
20943	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units)
20944	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for vaginal birth (8 basic units)
20946	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60 85% = \$140.10
		MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal gature (4 basic units)
20948	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units)
20950	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units)
20952	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic
20954	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50 85% = \$175.10
		MANAGEMENT OF ANAESTHESIA for evacuation of retained products of complication of confinement (4 basic units)
20956	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
		MANAGEMENT OF ANAESTHESIA for manual removal of retained placenta or for or perineal tear following birth (5 basic units)
	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55

ANAES ONLY P PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 8. PERINEUM
	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units)
20960	<b>Fee:</b> \$144.20 <b>Benefit:</b> 75% = \$108.15 85% = \$122.60
ANAES ONLY P PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN 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	<b>Fee:</b> \$61.80 <b>Benefit:</b> 75% = \$46.35 85% = \$52.55
	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	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)
21112	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)
21114	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units)
21116	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units)
21120	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for body cast application or revision when performed in the operating theatre of a hospital (3 basic units)
21130	<b>Fee:</b> \$61.80 <b>Benefit:</b> 75% = \$46.35 85% = \$52.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units)
21140	<b>Fee:</b> \$309.00 <b>Benefit:</b> 75% = \$231.75 85% = \$262.65
21150	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the

ANAES ONLY F PERFO	ELATIVE VALUE ( THESIA - MEDIC) PAYABLE FOR AI RMED IN ASSOC LE SERVICE	ARE BENEFITS ARE NAESTHESIA
	pelvis, except hi	nd-quarter amputation (10 basic units)
	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50 85% = \$175.10
		<sup>7</sup> MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery erior or posterior pelvis (10 basic units)
21155	(See para TN.10.2) <b>Fee:</b> \$206.00	B of explanatory notes to this Category) Benefit: $75\% = $154.50$ $85\% = $175.10$
		MANAGEMENT OF ANAESTHESIA for closed procedures involving symphysis c joint when performed in the operating theatre of a hospital (4 basic units)
21160	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
		MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis c joint (8 basic units)
21170	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60 85% = \$140.10
ONLY F PERFO		
ONLY F PERFO	THESIA - MEDIC PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela	ARE BENEFITS ARE VAESTHESIA IATION WITH AN
ONLY F PERFO	THESIA - MEDIC PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela	ARE BENEFITS ARE NAESTHESIA IATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
ONLY F PERFO	ATHESIA - MEDIC PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe	ARE BENEFITS ARE VAESTHESIA IATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service
ONLY F PERFO	ATHESIA - MEDIC PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe	ARE BENEFITS ARE NAESTHESIA IATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 10. Upper Leg (Except Knee) T MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous
ONLY F PERFO ELIGIB	THESIA - MEDIC PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe INITIATION OF tissue of the upport Fee: \$61.80 INITIATION OF	ARE BENEFITS ARE NAESTHESIA IATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 10. Upper Leg (Except Knee) 5 MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous or leg (3 basic units)
ONLY F PERFO ELIGIB	THESIA - MEDIC PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe INITIATION OF tissue of the upport Fee: \$61.80 INITIATION OF	ARE BENEFITS ARE NAESTHESIA JATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 10. Upper Leg (Except Knee) <sup>C</sup> MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er leg (3 basic units) Benefit: 75% = \$46.35 85% = \$52.55 <sup>C</sup> MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons,
ONLY F PERFO ELIGIB	THESIA - MEDICA PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe INITIATION OF tissue of the upport Fee: \$61.80 INITIATION OF fascia or bursae of Fee: \$82.40 INITIATION OF	ARE BENEFITS ARE NAESTHESIA JATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 10. Upper Leg (Except Knee) 7 MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er leg (3 basic units) Benefit: 75% = \$46.35 85% = \$52.55 7 MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, of the upper leg (4 basic units)
ONLY F PERFO ELIGIB	THESIA - MEDICA PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe INITIATION OF tissue of the upport Fee: \$61.80 INITIATION OF fascia or bursae of Fee: \$82.40 INITIATION OF	ARE BENEFITS ARE NAESTHESIA IATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 10. Upper Leg (Except Knee) <sup>7</sup> MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er leg (3 basic units) Benefit: 75% = \$46.35 85% = \$52.55 <sup>7</sup> MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, of the upper leg (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 <sup>7</sup> MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint whe
ONLY F PERFO ELIGIB 21195 21199	THESIA - MEDIC,         PAYABLE FOR AI         RMED IN ASSOC         LE SERVICE         Group T10. Rela         Anaesthesia Pe         INITIATION OF         tissue of the uppe         Fee: \$61.80         INITIATION OF         fascia or bursae of         Fee: \$82.40         INITIATION OF         performed in the         Fee: \$82.40	ARE BENEFITS ARE NAESTHESIA IATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 10. Upper Leg (Except Knee) <sup>7</sup> MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er leg (3 basic units) Benefit: 75% = \$46.35 85% = \$52.55 <sup>7</sup> MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, of the upper leg (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 <sup>7</sup> MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint whe operating theatre of a hospital (4 basic units)
ONLY F PERFO ELIGIB 21195 21199	THESIA - MEDIC,         PAYABLE FOR AI         RMED IN ASSOC         LE SERVICE         Group T10. Rela         Anaesthesia Pe         INITIATION OF         tissue of the upper         Fee: \$61.80         INITIATION OF         fascia or bursae of         Fee: \$82.40         INITIATION OF         performed in the         Fee: \$82.40         INITIATION OF         INITIATION OF	ARE BENEFITS ARE NAESTHESIA IATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 10. Upper Leg (Except Knee) 7 MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er leg (3 basic units) Benefit: 75% = \$46.35 85% = \$52.55 7 MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, of the upper leg (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05 7 MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint whe operating theatre of a hospital (4 basic units) Benefit: 75% = \$61.80 85% = \$70.05
ONLY F PERFO ELIGIB 21195 21199 21200	THESIA - MEDIC,         PAYABLE FOR AI         RMED IN ASSOC         LE SERVICE         Group T10. Rela         Anaesthesia Pe         INITIATION OF         tissue of the upp         Fee: \$61.80         INITIATION OF         fascia or bursae of         Fee: \$82.40         INITIATION OF         performed in the         Fee: \$82.40         INITIATION OF         basic units)         Fee: \$82.40         INITIATION OF         basic units)         Fee: \$82.40         INITIATION OF	ARE BENEFITS ARE VAESTHESIA IATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 10. Upper Leg (Except Knee) <sup>2</sup> MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er leg (3 basic units) <b>Benefit:</b> 75% = \$46.35 85% = \$52.55 <sup>2</sup> MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, of the upper leg (4 basic units) <b>Benefit:</b> 75% = \$61.80 85% = \$70.05 <sup>2</sup> MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint whe operating theatre of a hospital (4 basic units) <b>Benefit:</b> 75% = \$61.80 85% = \$70.05 <sup>3</sup> MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4

ANAES	ATIVE VALUE GUIDE FOR HESIA - MEDICARE BENEFITS ARE	
	AYABLE FOR ANAESTHESIA MED IN ASSOCIATION WITH AN	
	E SERVICE 10. UPPER LEG (EXCEPT K	NEE)
	INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units)	
21212	<b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total hip replacement or revision (10 units)	basic
21214	<b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 bas units)	sic
21216	<b>Fee:</b> \$288.40 <b>Benefit:</b> 75% = \$216.30 85% = \$245.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving upper 2/ femur when performed in the operating theatre of a hospital (4 basic units)	3 of
21220	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving upper 2/3 femur, not being a service to which another item in this Subgroup applies (6 basic units)	of
21230	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units	)
21232	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75% = \$77.25 85% = \$87.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of f (8 basic units)	emur
21234	<b>Fee:</b> \$164.80 <b>Benefit:</b> 75% = \$123.60 85% = \$140.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper l including exploration (4 basic units)	eg,
21260	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving arteries of uppe including bypass graft, not being a service to which another item in this Subgroup applies (8 basic u	
21270	<b>Fee:</b> \$164.80 <b>Benefit:</b> 75% = \$123.60 85% = \$140.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units)	,
21272	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic	units)
21274	(See para TN.10.24 of explanatory notes to this Category) <b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper leg (10 basic units)	τ
21275	(See para TN.10.28 of explanatory notes to this Category) <b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10	
21280	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of uppe	r leg

**10. UPPER LEG (EXCEPT KNEE)** 

(15 basic units)

Fee: \$309.00

**Benefit:** 75% = \$231.75 85% = \$262.65

### 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

		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service
		Subgroup 11. Knee And Popliteal Area
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous ee and/or popliteal area (3 basic units)
21300	Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35 85% = \$52.55
		F MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, of knee and/or popliteal area (4 basic units)
21321	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
		F MANAGEMENT OF ANAESTHESIA for closed procedures on lower 1/3 of femur l in the operating theatre of a hospital (4 basic units)
21340	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION O basic units)	F MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5
21360	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
		F MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when e operating theatre of a hospital (3 basic units)
21380	Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35 85% = \$52.55
	INITIATION O basic units)	F MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4
21382	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
		F MANAGEMENT OF ANAESTHESIA for closed procedures on upper ends of tibia, atella when performed in the operating theatre of a hospital (3 basic units)
21390	Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35 85% = \$52.55
		F MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, atella (4 basic units)
21392	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
21400	INITIATION O	F MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not being a

	11. K	NEE AND	POPLITEAL	AREA
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CLIGIDI	E SERVICE	11. KNEE AND POPLITEAL AREA
	service to which	another item in this Subgroup applies (4 basic units)
	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units)
21402	<b>Fee:</b> \$144.20	<b>Benefit:</b> 75% = \$108.15 85% = \$122.60
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units)
21403	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50 85% = \$175.10
		F MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units)
21404	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair oint, undertaken in a hospital (3 basic units)
21420	Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35 85% = \$52.55
		F MANAGEMENT OF ANAESTHESIA for procedures on veins of knee or popliteal a service to which another item in this Subgroup applies (4 basic units)
21430	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF popliteal area (5	F MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or basic units)
21432	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55
		F MANAGEMENT OF ANAESTHESIA for procedures on arteries of knee or popliteal service to which another item in this Subgroup applies (8 basic units)
21440	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60 85% = \$140.10
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery ee and/or popliteal area (10 basic units)
21445	(See para TN.10.2 <b>Fee:</b> \$206.00	8 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$154.50 85% = \$175.10
ANAES ONLY P PERFOI	AYABLE FOR A	ARE BENEFITS ARE
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service
		Subgroup 12. Lower Leg (Below Knee)
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous eg, ankle, or foot (3 basic units)
21460	Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35 85% = \$52.55
	1	

ANAEST ONLY P PERFOR	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN .E SERVICE 12. LOWER LEG (BELOW KNEE)
	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	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units)
21462	<b>Fee:</b> \$61.80 <b>Benefit:</b> 75% = \$46.35 85% = \$52.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4 basic units)
21464	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units)
21472	Fee: \$103.00 Benefit: 75% = \$77.25 85% = \$87.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units)
21474	Fee: \$103.00 Benefit: 75% = \$77.25 85% = \$87.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this Subgroup applies (4 basic units)
21480	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower leg, ankle or foot (5 basic units)
21482	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula (5 basic units)
21484	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units)
21486	<b>Fee:</b> \$144.20 <b>Benefit:</b> 75% = \$108.15 85% = \$122.60
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or repair, undertaken in a hospital (3 basic units)
21490	<b>Fee:</b> \$61.80 <b>Benefit:</b> 75% = \$46.35 85% = \$52.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units)
21500	<b>Fee:</b> \$164.80 <b>Benefit:</b> 75% = \$123.60 85% = \$140.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic units)
21502	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10

ANAES ONLY P PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 12. LOWER LEG (BELOW KNEE)
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of lower leg, not being a service to which another item in this Subgroup applies (4 basic units)
21520	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5 basic units)
21522	Fee: \$103.00         Benefit: 75% = \$77.25         85% = \$87.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg, ankle or foot (15 basic units)
21530	<b>Fee:</b> \$309.00 <b>Benefit:</b> 75% = \$231.75 85% = \$262.65
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8 basic units)
21532	<b>Fee:</b> \$164.80 <b>Benefit:</b> 75% = \$123.60 85% = \$140.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the lower leg (10 basic units)
21535	(See para TN.10.28 of explanatory notes to this Category) <b>Fee:</b> \$206.00 <b>Benefit:</b> 75% = \$154.50 85% = \$175.10
ANAES ONLY P PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE VAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE 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
	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	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous
21600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)
21600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)         Fee: \$61.80       Benefit: 75% = \$46.35       85% = \$52.55         INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons,
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)         Fee: \$61.80       Benefit: 75% = \$46.35       85% = \$52.55         INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units)
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)         Fee: \$61.80       Benefit: 75% = \$46.35       85% = \$52.55         INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units)         Fee: \$103.00       Benefit: 75% = \$77.25       85% = \$87.55         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

13. SHOULDER AND AXILLA

	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25	85% = \$87.55
	neck, sternoclavi		AESTHESIA for open procedures on humeral head and lar joint or shoulder joint, not being a service to which ic units)
21630	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25	85% = \$87.55
			AESTHESIA for radical resection involving humeral head vicular joint or shoulder joint (6 basic units)
21632	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70	85% = \$105.10
	INITIATION OF	MANAGEMENT OF AN	AESTHESIA for shoulder disarticulation (9 basic units)
21634	Fee: \$185.40	<b>Benefit:</b> 75% = \$139.05	85% = \$157.60
	INITIATION OF amputation (15 b		AESTHESIA for interthoracoscapular (forequarter)
21636	Fee: \$309.00	<b>Benefit:</b> 75% = \$231.75	85% = \$262.65
	INITIATION OF	MANAGEMENT OF AN	AESTHESIA for total shoulder replacement (10 basic units)
21638	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10
			AESTHESIA for procedures on arteries of shoulder or item in this Subgroup applies (8 basic units)
21650	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60	85% = \$140.10
	INITIATION OF (10 basic units)	MANAGEMENT OF AN	AESTHESIA for procedures for axillary-brachial aneurysm
21652	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10
	INITIATION OF axilla (8 basic un		AESTHESIA for bypass graft of arteries of shoulder or
21654	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60	85% = \$140.10
	INITIATION OF units)	MANAGEMENT OF AN	AESTHESIA for axillary-femoral bypass graft (10 basic
21656	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50	85% = \$175.10
	INITIATION OF (4 basic units)	MANAGEMENT OF AN	AESTHESIA for procedures on veins of shoulder or axilla
21670	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80	85% = \$70.05
			AESTHESIA for shoulder cast application, removal or item in this Subgroup applies, when undertaken in a hospital
21680	Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35	85% = \$52.55
21682	INITIATION OF	MANAGEMENT OF AN	AESTHESIA for shoulder spica application when

T10 DE		EOP	
	LATIVE VALUE GUIDE THESIA - MEDICARE BI		
	AYABLE FOR ANAEST RMED IN ASSOCIATION		
-	LE SERVICE		13. SHOULDER AND AXILLA
	undertaken in a hospital	(4 basic units)	
	Fee: \$82.40 Ber	<b>nefit:</b> 75% = \$61.80	85% = \$70.05
	INITIATION OF MANA involving the shoulder of		NAESTHESIA for microvascular free tissue flap surgery ic units)
21685	(See para TN.10.28 of expl <b>Fee:</b> \$206.00 <b>Ben</b>	anatory notes to this ( <b>nefit:</b> 75% = \$154.50	
ANAES ONLY F PERFO	LATIVE VALUE GUIDE THESIA - MEDICARE BI AYABLE FOR ANAEST RMED IN ASSOCIATION	ENEFITS ARE HESIA	
ELIGIB			14. UPPER ARM AND ELBOW
	Group T10. Relative Va Anaesthesia Performed		aesthesia - Medicare Benefits Are Only Payable For /ith An Eligible Service
		Subgrou	up 14. Upper Arm And Elbow
	INITIATION OF MANA tissue of the upper arm o		NAESTHESIA for procedures on the skin or subcutaneous nits)
21700	Fee: \$61.80 Ber	<b>nefit:</b> 75% = \$46.35	85% = \$52.55
			NAESTHESIA for procedures on nerves, muscles, tendons, being a service to which another item in this Subgroup
21710	Fee: \$82.40 Ber	<b>nefit:</b> 75% = \$61.80	85% = \$70.05
	INITIATION OF MANA (5 basic units)	AGEMENT OF AN	VAESTHESIA for open tenotomy of the upper arm or elbow
21712	Fee: \$103.00 Ber	<b>nefit:</b> 75% = \$77.25	85% = \$87.55
	INITIATION OF MANA basic units)	AGEMENT OF AN	VAESTHESIA for tenoplasty of the upper arm or elbow (5
21714	Fee: \$103.00 Ber	<b>nefit:</b> 75% = \$77.25	85% = \$87.55
	INITIATION OF MANA biceps (5 basic units)	AGEMENT OF AN	VAESTHESIA for tenodesis for rupture of long tendon of
21716	Fee: \$103.00 Ber	<b>nefit:</b> 75% = \$77.25	85% = \$87.55
			NAESTHESIA for closed procedures on the upper arm theatre of a hospital (3 basic units)
21730	Fee: \$61.80 Ber	<b>nefit:</b> 75% = \$46.35	85% = \$52.55
	INITIATION OF MANA basic units)	AGEMENT OF AN	NAESTHESIA for arthroscopic procedures of elbow joint (4
21732	Fee: \$82.40 Ber	<b>nefit:</b> 75% = \$61.80	85% = \$70.05
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T10. RELATIVE VALUE GUIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
ONLY PAYABLE FOR ANAESTHESIA
PERFORMED IN ASSOCIATION WITH AN
ELIGIBLE SERVICE

14. UPPER ARM AND ELBOW

	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	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75% = \$77.25 85% = \$87.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or elbow (6 basic units)
21756	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units)
21760	<b>Fee:</b> \$144.20 <b>Benefit:</b> 75% = \$108.15 85% = \$122.60
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of upper arm, not being a service to which another item in this Subgroup applies (8 basic units)
21770	<b>Fee:</b> \$164.80 <b>Benefit:</b> 75% = \$123.60 85% = \$140.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm (6 basic units)
21772	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of upper arm, not being a service to which another item in this Subgroup applies (4 basic units)
21780	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper arm or elbow (10 basic units)
21785	(See para TN.10.28 of explanatory notes to this Category)         Fee: \$206.00       Benefit: 75% = \$154.50       85% = \$175.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm (15 basic units)
21790	<b>Fee:</b> \$309.00 <b>Benefit:</b> 75% = \$231.75 85% = \$262.65
ANAES ONLY P PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 15. FOREARM WRIST AND HAND
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 15. Forearm Wrist And Hand
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units)
21800	<b>Fee:</b> \$61.80 <b>Benefit:</b> 75% = \$46.35 85% = \$52.55
21810	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the nerves, muscles,

<b>15. FOREARM WRIST AND HAND</b>
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	tendons, fascia,	or bursae of the forearm, wrist or hand (4 basic units)		
	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05		
		F MANAGEMENT OF ANAESTHESIA for closed procedures on the radius, ulna, ones when performed in the operating theatre of a hospital (3 basic units)		
21820	Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35 85% = \$52.55		
		F MANAGEMENT OF ANAESTHESIA for open procedures on the radius, ulna, wrist, ot being a service to which another item in this Subgroup applies (4 basic units)		
21830	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05		
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units)		
21832	Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15 85% = \$122.60		
	INITIATION O (4 basic units)	F MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint		
21834	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05		
		F MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist ag a service to which another item in this Subgroup applies (8 basic units)		
21840	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60 85% = \$140.10		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units)			
21842	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10		
		F MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist ag a service to which another item in this Subgroup applies (4 basic units)		
21850	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05		
		F MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, ir when rendered to a patient as part of an episode of hospital treatment (3 basic units)		
21860	Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35 85% = \$52.55		
INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue fl involving the forearm, wrist or hand (10 basic units)				
21865	(See para TN.10.2 <b>Fee:</b> \$206.00	8 of explanatory notes to this Category) Benefit: $75\% = \$154.50$ $85\% = \$175.10$		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm, wrist or hand (15 basic units)			
21870	Fee: \$309.00	<b>Benefit:</b> 75% = \$231.75 85% = \$262.65		
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (8		
21872	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60 85% = \$140.10		

#### **T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA** PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE **16. ANAESTHESIA FOR BURNS** Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 16. Anaesthesia For Burns INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface (3 basic units) Fee: \$61.80 **Benefit:** 75% = \$46.35 85% = \$52.55 21878 INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves more than 3% but less than 10% of total body surface (5 basic units) 21879 Fee: \$103.00 **Benefit:** 75% = \$77.25 85% = \$87.55 INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (7 basic units) 21880 Fee: \$144.20 **Benefit:** 75% = \$108.15 85% = \$122.60 INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units) 21881 Fee: \$185.40 **Benefit:** 75% = \$139.05 85% = \$157.60 INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (11 basic units) 21882 Fee: \$226.60 **Benefit:** 75% = \$169.95 85% = \$192.65 INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (13 basic units) Fee: \$267.80 **Benefit:** 75% = \$200.85 85% = \$227.65 21883 INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units) 21884 Fee: \$309.00 **Benefit:** 75% = \$231.75 85% = \$262.65 INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units) **Benefit:** 75% = \$262.65 85% = \$297.70 21885 Fee: \$350.20 INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body 21886

	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE		
ONLY F	AYABLE FOR ANAESTHESIA		
	RMED IN ASSOCIATION WITH AN LE SERVICE 16. ANAESTHESIA FOR BURN		
	surface (19 basic units)		
	<b>Fee:</b> \$391.40 <b>Benefit:</b> 75% = \$293.55 85% = \$332.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with o without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic unit		
21887	Fee: \$432.60         Benefit: 75% = \$324.45         85% = \$367.75		
ANAES ONLY F PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA 17. ANAESTHESIA FOR RADIOLOGICAL C RMED IN ASSOCIATION WITH AN OTHER DIAGNOSTIC OR THERAPEUT E SERVICE PROCEDURE		
	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: \$61.80         Benefit: 75% = \$46.35         85% = \$52.55		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units)		
21906	Fee: \$103.00         Benefit: 75% = \$77.25         85% = \$87.55		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: cervical (6 basic units)		
21908	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units)		
21910	Fee: \$185.40         Benefit: 75% = \$139.05         85% = \$157.60		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: lumbar or thoracic (5 basic units)		
21912	Fee: \$103.00         Benefit: 75% = \$77.25         85% = \$87.55		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: cervical (6 basic units)		
21914	<b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units)		
21915	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75% = \$77.25 85% = \$87.55		
21916	INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebra (5 basic units)		

### 17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55			
INITIATION OF (5 basic units)	MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femora			
Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55			
	MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, ee scanning, digital subtraction angiography scanning (6 basic units)			
Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10			
INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units)				
Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05			
INITIATION OF	MANAGEMENT OF ANAESTHESIA for fluoroscopy (4 basic units)			
Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05			
INITIATION OF	MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units)			
Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105.10			
INITIATION OF	MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units)			
Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55			
INITIATION OF MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time				
transoesophageal examination (5 basic units)				
	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$77.25 85% = \$87.55			
INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic units)				
Fee: \$61.80	<b>Benefit:</b> 75% = \$46.35 85% = \$52.55			
INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker (7 basic units)				
(See para TN.10.25 of explanatory notes to this Category) 41 <b>Fee:</b> \$144.20 <b>Benefit:</b> 75% = \$108.15 85% = \$122.60				
INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures including radio frequency ablation (10 basic units)				
Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50 85% = \$175.10			
INITIATION OF MANAGEMENT OF ANAESTHESIA for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (5 basic units)				
Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55			
INITIATION OF	MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or			
	<ul> <li>INITIATION OF I (5 basic units)</li> <li>Fee: \$103.00</li> <li>INITIATION OF I magnetic resonance</li> <li>Fee: \$123.60</li> <li>INITIATION OF I urethrography or resonance</li> <li>Fee: \$82.40</li> <li>INITIATION OF I</li> <li>Fee: \$82.40</li> <li>INITIATION OF I</li> <li>Fee: \$123.60</li> <li>INITIATION OF I</li> <li>Fee: \$103.00</li> <li>INITIATION OF I</li> <li>transoesophageal e</li> <li>(See para TN.10.26 e</li> <li>Fee: \$61.80</li> <li>INITIATION OF I</li> <li>units)</li> <li>Fee: \$61.80</li> <li>INITIATION OF I</li> <li>arteriography, ven pacemaker (7 basic</li> <li>(See para TN.10.25 e</li> <li>Fee: \$144.20</li> <li>INITIATION OF I</li> <li>including radio free</li> <li>Fee: \$206.00</li> <li>INITIATION OF I</li> <li>right heart balloon (5 basic units)</li> <li>Fee: \$103.00</li> </ul>			

#### 17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

CLIGID	LE SERVICE	FROCEDURES	
	epidural injection	n (5 basic units)	
	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55	
	INITIATION OF of transplantation	F MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose n (5 basic units)	
21949	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55	
	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia (4 basic units)		
21952	Fee: \$82.40	<b>Benefit:</b> 75% = \$61.80 85% = \$70.05	
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units)	
21955	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55	
	INITIATION OF basic units)	F MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5	
21959	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units)		
21962	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA as a therapeutic procedure if there is a clinical need for anaesthesia, not for headache of any etiology (5 basic units)		
21965	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units)		
21969	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60 85% = \$140.10	
	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)		
21970	Fee: \$309.00	<b>Benefit:</b> 75% = \$231.75 85% = \$262.65	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed sources (5 basic units)		
21973	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55	
	INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic	
21976	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55	
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units)	
21980	Fee: \$103.00	<b>Benefit:</b> 75% = \$77.25 85% = \$87.55	
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ANAES	LATIVE VALUE GUIDE FOR
	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA
	RMED IN ASSOCIATION WITH AN
ELIGIB	LE SERVICE 18. MISCELLANEOUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 18. Miscellaneous
	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units)
21990	(See para TN.10.12 of explanatory notes to this Category)           Fee: \$61.80         Benefit: 75% = \$46.35         85% = \$52.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (4 basic units)
21992	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 85% = \$70.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA in connection with a procedure covered by an 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)
21997	(See para TN.10.13 of explanatory notes to this Category) <b>Fee:</b> $\$2.40$ <b>Benefit:</b> $75\% = \$61.80$ $\$5\% = \$70.05$
PERFO	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN
PERFO	PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 19. THERAPEUTIC AND DIAGNOSTIC SERVICES Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
PERFO	PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 19. THERAPEUTIC AND DIAGNOSTIC SERVICES
PERFO	PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 19. THERAPEUTIC AND DIAGNOSTIC SERVICES Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
PERFO	PAYABLE FOR ANAESTHESIA         RMED 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
PERFO	PAYABLE FOR ANAESTHESIA         RMED 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
PERFO	PAYABLE FOR ANAESTHESIA RMED 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: \$82.40         Benefit: 75% = \$61.80       85% = \$70.05
22002	PAYABLE FOR ANAESTHESIA RMED 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: \$82.40         Benefit: 75% = \$61.80       85% = \$70.05         ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when
PERFO	PAYABLE FOR ANAESTHESIA RMED 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: \$82.40         Benefit: 75% = \$61.80       85% = \$70.05         ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units)
PERFO ELIGIB	PAYABLE FOR ANAESTHESIA RMED 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: \$82.40         Benefit: 75% = \$61.80       85% = \$70.05         ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units)         Fee: \$82.40       Benefit: 75% = \$61.80       85% = \$70.05         DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when
22002	PAYABLE FOR ANAESTHESIA RMED 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: \$82.40         Benefit: 75% = \$61.80       85% = \$70.05         ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units)         Fee: \$82.40       Benefit: 75% = \$61.80       85% = \$70.05         DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units)

# 19. THERAPEUTIC AND DIAGNOSTIC SERVICES

	complications or a high risk of complications (3 basic units)
	(See para TN.10.8 of explanatory notes to this Category)Fee: $$61.80$ Benefit: $75\% = $46.35$ $85\% = $52.55$
	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient: (a) when performed in association with the management of anaesthesia for the patient; and (b) relating to another discrete operation on the same day for the patient; and (c) other than a service to which item 13876 applies (d) who is categorised as having a high risk of complications or develops during the current procedure either complications or a high risk of complications (3 basic units)
22014	(See para TN.10.8 of explanatory notes to this Category)Fee: $$61.80$ Benefit: $75\% = $46.35$ $85\% = $52.55$
	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the administration of anaesthesia (6 basic units)
22015	(See para TN.10.8 of explanatory notes to this Category) <b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 85% = \$105.10
	CENTRAL VEIN CATHETERISATION by percutaneous or open exposure, not being a service to which item 13318 applies, when performed in association with the administration of anaesthesia (4 basic units)
22020	(See para TN.1.6, TN.10.8 of explanatory notes to this Category)Fee: $\$82.40$ Benefit: $75\% = \$61.80$ $85\% = \$70.05$
	Intra-arterial cannulation when performed in association with the management of anaesthesia in a patient who: (a) is categorised as having a high risk of complications; or (b) develops a high risk of complications during the procedure (4 basic units)
22025	(See para TN.10.8 of explanatory notes to this Category)           Fee: \$82.40         Benefit: 75% = \$61.80         85% = \$70.05
	Intrathecal or epidural injection (initial) of a therapeutic substance or substances, with or without insertion of a catheter, in association with anaesthesia and surgery, for post-operative pain management, not being a service to which 22036 applies (5 basic units)
22031	(See para TN.10.17 of explanatory notes to this Category)           Fee: \$103.00         Benefit: 75% = \$77.25         85% = \$87.55
	INTRATHECAL or EPIDURAL INJECTION (subsequent) of a therapeutic substance or substances, using an in-situ catheter, in association with anaesthesia and surgery, for postoperative pain management, not being a service associated with a service to which 22031 applies (3 basic units)
22036	(See para TN.10.17 of explanatory notes to this Category)           Fee:         \$61.80         Benefit:         75% = \$46.35         85% = \$52.55
	Perioperative introduction of a plexus or nerve block proximal to the lower leg or forearm for post operative pain management (2 basic units)
22041	(See para TN.10.17 of explanatory notes to this Category)

19. THERAPEUTIC AND DIAGNOSTIC SERVICES

ELIGIBLE SERVICE       CONNECTION WITH A DENTAL SERV         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)	CLIGIDI	E SERVICE		19. THERAPEUTIC AND DIAGNOSTIC SERVICES
complex eye block, when administered by an anaesthetist perioperatively (1 basic units)         (See para TN.10.8 of explanatory notes to this Category)         Fee: \$20.60       Benefit: 75% = 515.45         INTRA-OPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY - Monitoring in real tim the structure and function of the heart chambers, valves and surrounding structures, including assess 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: \$183.40       Benefit: 75% = \$139.05       85% = \$157.60         PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units)       (See para TN.10.10 of explanatory notes to this Category)         Fee: \$247.20       Benefit: 75% = \$185.40       85% = \$210.15         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)         (See para TN.10.10, TN.10.3 of explanatory notes to this Category)         Fee: \$103.00       Benefit: 75% = \$463.50       85% = \$533.30         INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 appli not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)         (See para TN		Fee: \$41.20	<b>Benefit:</b> 75% = \$30.90	0 85% = \$35.05
22042         Fee: \$20.60         Benefit: 75% = \$15.45         85% = \$17.55           INTRA-OPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY - Monitoring in real tim the structure and function of the heart chambers, valves and surrounding structures, including assess of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or 21936) (9 basic units)           22051         Fee: \$185.40         Benefit: 75% = \$139.05         85% = \$157.60           22051         Fee: \$185.40         Benefit: 75% = \$139.05         85% = \$210.15           2055         Fee: \$247.20         Benefit: 75% = \$185.40         85% = \$210.15           2060         Fee: \$247.20         Benefit: 75% = \$185.40         85% = \$210.15           2070         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)           2060         Fee: \$18.00         Benefit: 75% = \$403.00         85% = \$33.30           20700         Fee: \$103.00         Benefit: 75% = \$77.25         85% = \$87.55           2085         Fee: \$103.00         Benefit: 75% = \$77.25         85% = \$87.55           2085         Fee: \$103.00         Benefit: 75% = \$231.75         85% = \$242.65           20.40         Benefit: 75%				
the structure and function of the heart chambers, valves and surrounding structures, including assess 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: \$185.40       Benefit: 75% = \$139.05         22051       Fee: \$185.40         Benefit: 75% = \$139.05       85% = \$157.60         22055       Fee: \$247.20         Benefit: 75% = \$185.40       85% = \$210.15         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)         (See para TN.10.10, TN.10.3 of explanatory notes to this Category)         22060       Fee: \$618.00         Benefit: 75% = \$77.25       85% = \$87.55         DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$013.00       Benefit: 75% = \$77.25         Benefit: 75% = \$77.25       85% = \$85.55         DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral pe	22042			
22051       Fee: \$185.40       Benefit: 75% = \$139.05 $85\%$ = \$157.60         PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$247.20       Benefit: 75% = \$185.40       85% = \$210.15         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)         (See para TN.10.10, TN.10.3 of explanatory notes to this Category)         Fee: \$618.00       Benefit: 75% = \$463.50       85% = \$533.30         INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 appli not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$103.00       Benefit: 75% = \$77.25         DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)         (See para TN.10.10 of explanatory notes to this Category)         DEEP HYPOTHERMIC CIRCULATORY ARREST, with core tempe		the structure and of blood flow, w	d function of the heart char with appropriate permanent	mbers, valves and surrounding structures, including assessment recording during procedures on the heart, pericardium or
associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$247.20       Benefit: 75% = \$185.40       85% = \$210.15         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)         (See para TN.10.10, TN.10.3 of explanatory notes to this Category)         Fee: \$618.00       Benefit: 75% = \$463.50         22060       Fee: \$618.00       Benefit: 75% = \$463.50         NDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 appli not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$103.00       Benefit: 75% = \$77.25         Z055       Fee: \$103.00       Benefit: 75% = \$77.25         Z056       Fee: \$103.00       Benefit: 75% = \$231.75         Z057       Fee: \$103.00       Benefit: 75% = \$231.75         Z058       See para TN.10.10 of explanatory notes to this Category)         Fee: \$103.00       Benefit: 75% = \$231.75         Z057       Fee: \$103.00       Benefit: 75% = \$231.75         Z058       See para TN.10.10 of explanatory notes to this Category)	22051			
22055       Fee: \$247.20       Benefit: 75% = \$185.40       85% = \$210.15         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)         (See para TN.10.10, TN.10.3 of explanatory notes to this Category)         Fee: \$618.00       Benefit: 75% = \$463.50       85% = \$533.30         INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 appli not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic unit)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$103.00       Benefit: 75% = \$77.25         DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$309.00       Benefit: 75% = \$231.75       85% = \$87.55         DEEP HYPOTHERMIC CIRCULA TORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)         (See para TN.10.10 of explanatory notes to this Category)				
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)         (See para TN.10.10, TN.10.3 of explanatory notes to this Category)         Fee: \$618.00       Benefit: 75% = \$463.50       85% = \$533.30         INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 appli not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$103.00       Benefit: 75% = \$77.25       85% = \$87.55         DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$309.00       Benefit: 75% = \$231.75       85% = \$262.65         T10. RELATIVE VALUE GUIDE FOR         ANAESTHESIA - MEDICARE BENEFITS ARE         ONLY PAYABLE FOR ANAESTHESIA         PERFORMED IN ASSOCIATION WITH AN         ELIGIBLE SERVICE         Connection With A DENTAL SERV         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	22055			
22060       Fee: \$618.00       Benefit: 75% = \$463.50       85% = \$533.30         INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 applinot being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$103.00       Benefit: 75% = \$77.25       85% = \$87.55         DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)         (See para TN.10.10 of explanatory notes to this Category)         PEE: \$309.00       Benefit: 75% = \$231.75         State of the second of the se		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		
and being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$103.00       Benefit: 75% = \$77.25         DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$309.00       Benefit: 75% = \$231.75         85% = \$262.65         T10. RELATIVE VALUE GUIDE FOR         ANAESTHESIA - MEDICARE BENEFITS ARE         ONLY PAYABLE FOR ANAESTHESIA         PERFORMED IN ASSOCIATION WITH AN         ELIGIBLE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 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)	22060			
22065       Fee: \$103.00       Benefit: 75% = \$77.25       85% = \$87.55         DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$309.00       Benefit: 75% = \$231.75       85% = \$262.65         T10. RELATIVE VALUE GUIDE FOR         ANAESTHESIA - MEDICARE BENEFITS ARE         ONLY PAYABLE FOR ANAESTHESIA         PERFORMED IN ASSOCIATION WITH AN         ELIGIBLE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service         Subgroup 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)				
management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)         (See para TN.10.10 of explanatory notes to this Category)         Fee: \$309.00       Benefit: 75% = \$231.75       85% = \$262.65         T10. RELATIVE VALUE GUIDE FOR         ANAESTHESIA - MEDICARE BENEFITS ARE         ONLY PAYABLE FOR ANAESTHESIA         PERFORMED IN ASSOCIATION WITH AN         ELIGIBLE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 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)	22065			
22075       Fee: \$309.00       Benefit: 75% = \$231.75       85% = \$262.65         T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE       20. ADMINISTRATION OF ANAESTHESIA CONNECTION WITH A DENTAL SERV         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)		management of	retrograde cerebral perfusi	ion if performed, not being a service associated with
ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE 20. ADMINISTRATION OF ANAESTHESIA CONNECTION WITH A DENTAL SERV 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)	22075			
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)	ANAES <sup>®</sup> ONLY P PERFOI	THESIA - MEDIO AYABLE FOR A RMED IN ASSO	CARE BENEFITS ARE	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)				
extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units)		Si	bgroup 20. Administration	Of Anaesthesia In Connection With A Dental Service
22900	22900			

ANAES	T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE				
PERFO	AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN _E SERVICE	20. ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE			
	(See para TN.10.14 of explanatory notes to this Cat Fee: \$123.60 Benefit: 75% = \$92.70 8				
	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units)				
22905	(See para TN.10.14 of explanatory notes to this Cat <b>Fee:</b> \$123.60 <b>Benefit:</b> 75% = \$92.70 8				
ANAES <sup>®</sup> ONLY P PERFOI	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE YAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS			
	Group T10. Relative Value Guide For Anaes Anaesthesia Performed In Association With	thesia - Medicare Benefits Are Only Payable For An Eligible Service			
	Subgroup 21. Ar	naesthesia/Perfusion Time Units			
	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA				
(a) administration of anaesthesia performed in association with an item in the range 201 22900 to 22905; or					
	(b) perfusion performed in association with item 22060; or				
	(c) for assistance at anaesthesia performed in a	association with items 25200 to 25205			
	For a period of:				
	(FIFTEEN MINUTES OR LESS) (1 basic uni	ts)			
23010	(See para TN.10.3 of explanatory notes to this CateFee: $$20.60$ Benefit: $75\% = $15.45$				
	16 MINUTES TO 30 MINUTES (2 basic unit	s)			
23025	<b>Fee:</b> \$41.20 <b>Benefit:</b> 75% = \$30.90 8	\$5% = \$35.05			
	31 MINUTES to 45 MINUTES (3 basic units)				
23035	<b>Fee:</b> \$61.80 <b>Benefit:</b> 75% = \$46.35 8	5% = \$52.55			
	46 MINUTES to 1:00 HOUR (4 basic units)				
23045	<b>Fee:</b> \$82.40 <b>Benefit:</b> 75% = \$61.80 8	5% = \$70.05			
	1:01 HOURS to 1:15 HOURS (5 basic units)				
23055	<b>Fee:</b> \$103.00 <b>Benefit:</b> 75% = \$77.25 8	5% = \$87.55			

ANAES <sup>.</sup> ONLY P	AYABLE FOR A	ARE BENEFITS ARE	
	E SERVICE		ANAESTHESIA/PERFUSION TIME UNITS
	1:16 HOURS to	1:30 HOURS (6 basic units)	
23065	Fee: \$123.60	<b>Benefit:</b> 75% = \$92.70 85% = \$105	10
	1:31 HOURS to	1:45 HOURS (7 basic units)	
23075	Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15 85% = \$12	2.60
	1:46 HOURS to	2:00 HOURS (8 basic units)	
23085	Fee: \$164.80	<b>Benefit:</b> 75% = \$123.60 85% = \$14	0.10
		O 2:10 HOURS (9 basic units)	
22001	Fee: \$185.40	<b>Benefit:</b> 75% = \$139.05 85% = \$15	7.60
23091		<b>Benefit:</b> $75\% = $139.05$ $85\% = $15$ O 2:20 HOURS (10 basic units)	7.00
23101	Fee: \$206.00	<b>Benefit:</b> 75% = \$154.50 85% = \$17	5.10
	2:21 HOURS T	O 2:30 HOURS (11 basic units)	
23111	Fee: \$226.60	<b>Benefit:</b> 75% = \$169.95 85% = \$19	2.65
	2:31 HOURS T	O 2:40 HOURS (12 basic units)	
23112	Fee: \$247.20	<b>Benefit:</b> 75% = \$185.40 85% = \$21	0.15
	2:41 HOURS TO 2:50 HOURS (13 basic units)		
23113	Fee: \$267.80	<b>Benefit:</b> 75% = \$200.85 85% = \$22	7.65
	2:51 HOURS T	O 3:00 HOURS (14 basic units)	
23114	Fee: \$288.40	<b>Benefit:</b> 75% = \$216.30 85% = \$24	5.15
		O 3:10 HOURS (15 basic units)	
23115	Fee: \$309.00	<b>Benefit:</b> 75% = \$231.75 85% = \$26	2.65
20110	Fee: \$309.00         Benefit: 75% = \$231.75         85% = \$262.65           3:11 HOURS TO 3:20 HOURS (16 basic units)		
23116	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20 85% = \$28	0.20
23110		O 3:30 HOURS (17 basic units)	
22115			
23117	<b>Fee:</b> \$350.20	<b>Benefit:</b> $75\% = $262.65  85\% = $29$	/./0
	3:31 HOURS TO 3:40 HOURS (18 basic units)		
23118	Fee: \$370.80	<b>Benefit:</b> 75% = \$278.10 85% = \$31	5.20
	3:41 HOURS T	O 3:50 HOURS (19 basic units)	
23119	Fee: \$391.40	<b>Benefit:</b> 75% = \$293.55 85% = \$33	2.70
	3:51 HOURS T	O 4:00 HOURS (20 basic units)	
23121	Fee: \$412.00	<b>Benefit:</b> 75% = \$309.00 85% = \$35	0.20

T10. RE		GUIDE FOR	
	THESIA - MEDIC PAYABLE FOR A	ARE BENEFITS ARE	
		CIATION WITH AN	
ELIGIBI			21. ANAESTHESIA/PERFUSION TIME UNITS
	4:01 HOURS TO	0 4:10 HOURS (21 basic unit	ts)
23170	Fee: \$432.60	<b>Benefit:</b> 75% = \$324.45	85% = \$367.75
	4:11 HOURS TO	0 4:20 HOURS (22 basic unit	ts)
23180	Fee: \$453.20	<b>Benefit:</b> 75% = \$339.90	85% = \$385.25
	4:21 HOURS TO	0 4:30 HOURS (23 basic unit	ts)
23190	Fee: \$473.80	<b>Benefit:</b> 75% = \$355.35	85% = \$402.75
	4:31 HOURS TO	O 4:40 HOURS (24 basic unit	ts)
23200	Fee: \$494.40	<b>Benefit:</b> 75% = \$370.80	85% = \$420.25
		0.4:50  HOURS (25  basic unit)	
23210	Fee: \$515.00	<b>Benefit:</b> 75% = \$386.25	<i>`</i>
25210	-	5:00  HOURS (26  basic unit)	
23220	<b>Fee:</b> \$535.60	<b>Benefit:</b> 75% = \$401.70 D 5:10 HOURS (27 basic unit	
23230	Fee: \$556.20	<b>Benefit:</b> 75% = \$417.15	
	5:11 HOURS TO	0 5:20 HOURS (28 basic unit	S)
23240	Fee: \$576.80	<b>Benefit:</b> 75% = \$432.60	
	5:21 HOURS TO	0 5:30 HOURS (29 basic unit	is)
23250	Fee: \$597.40	<b>Benefit:</b> 75% = \$448.05	85% = \$512.70
	5:31 HOURS TO 5:40 HOURS (30 basic units)		
23260	Fee: \$618.00	<b>Benefit:</b> 75% = \$463.50	85% = \$533.30
	5:41 HOURS TO 5:50 HOURS (31 basic units)		
23270	Fee: \$638.60	<b>Benefit:</b> 75% = \$478.95	85% = \$553.90
	(5:51 HOURS T	O 6:00 HOURS (32 basic uni	its)
23280	Fee: \$659.20	<b>Benefit:</b> 75% = \$494.40	85% = \$574.50
		D 6:10 HOURS (33 basic unit	
23290	Fee: \$679.80	<b>Benefit:</b> 75% = \$509.85	85% - \$595.10
23270	-	0 6:20 HOURS (34 basic unit	
22200		,	
23300	Fee: \$700.40	<b>Benefit:</b> $75\% = $525.30$	
	6:21 HOURS TO 6:30 HOURS (35 basic units)		
23310	Fee: \$721.00	<b>Benefit:</b> 75% = \$540.75	85% = \$636.30

T10. RE			
ANAES	THESIA - MEDIC	ARE BENEFITS ARE	
	PAYABLE FOR AN RMED IN ASSOC		
	LE SERVICE		21. ANAESTHESIA/PERFUSION TIME UNITS
	6:31 HOURS TO	6:40 HOURS (36 basic units	)
23320	Fee: \$741.60	<b>Benefit:</b> 75% = \$556.20	85% = \$656.90
	6:41 HOURS TO	6:50 HOURS (37 basic units	)
23330	Fee: \$762.20	<b>Benefit:</b> 75% = \$571.65	85% = \$677.50
	6:51 HOURS TO	7:00 HOURS (38 basic units	)
23340	Fee: \$782.80	<b>Benefit:</b> 75% = \$587.10	85% = \$698.10
	7:01 HOURS TO	7:10 HOURS (39 basic units	)
23350	<b>Fee:</b> \$803.40	<b>Benefit:</b> 75% = \$602.55	85% = \$718.70
		7:20 HOURS (40 basic units	
23360	<b>Fee:</b> \$824.00	<b>Benefit:</b> 75% = \$618.00	85% = \$739.30
23300		7:30 HOURS (41 basic units	
23370	Fee: \$844.60	<b>Benefit:</b> 75% = \$633.45	85% - \$759.90
23370		7:40 HOURS (42 basic units	
23380	Fee: \$865.20	<b>Benefit:</b> 75% = \$648.90	, ,
25560		7:50  HOURS (43  basic units)	
22200			, ,
23390	<b>Fee:</b> \$885.80	<b>Benefit:</b> 75% = \$664.35 8 8:00 HOURS (44 basic units	
			, ,
23400	<b>Fee:</b> \$906.40	<b>Benefit:</b> 75% = \$679.80	
	8:01 HOURS TO	8:10 HOURS (45 basic units	)
23410	<b>Fee:</b> \$927.00	<b>Benefit:</b> 75% = \$695.25	
	8:11 HOURS TO	8:20 HOURS (46 basic units	)
23420	Fee: \$947.60	<b>Benefit:</b> 75% = \$710.70	35% = \$862.90
	8:21 HOURS TO	8:30 HOURS (47 basic units	)
23430	Fee: \$968.20	<b>Benefit:</b> 75% = \$726.15	35% = \$883.50
	8:31 HOURS TO	8:40 HOURS (48 basic units	)
23440	Fee: \$988.80	<b>Benefit:</b> 75% = \$741.60	35% = \$904.10
	8:41 HOURS TO	8:50 HOURS (49 basic units	)
23450	Fee: \$1,009.40	<b>Benefit:</b> 75% = \$757.05	35% = \$924.70
	8:51 HOURS TO	9:00 HOURS (50 basic units	)
23460	Fee: \$1,030.00	<b>Benefit:</b> 75% = \$772.50	35% = \$945.30
	1		

T10 RF	LATIVE VALUE GUID		
-	HESIA - MEDICARE	-	
-	AYABLE FOR ANAE		
	E SERVICE		21. ANAESTHESIA/PERFUSION TIME UNITS
	9:01 HOURS TO 9:10	HOURS (51 basic uni	ts)
23470	Fee: \$1,050.60	<b>Benefit:</b> 75% = \$787.95	85% - \$965.90
23470	. ,	) HOURS (52 basic uni	
22490		,	
23480		Benefit: 75% = \$803.40 ) HOURS (53 basic uni	
	9.21 HOURS TO 9.50	TIOOKS (55 basic uni	(5)
23490		<b>Benefit:</b> 75% = \$818.85	
	9:31 HOURS TO 9:40	) HOURS (54 basic uni	ts)
23500	Fee: \$1,112.40	<b>Benefit:</b> 75% = \$834.30	85% = \$1027.70
	9:41 HOURS TO 9:50	HOURS (55 basic uni	ts)
23510	Fee: \$1,133.00	<b>Benefit:</b> 75% = \$849.75	85% = \$1048.30
	9:51 HOURS TO 10:0	00 HOURS (56 basic ur	nits)
23520	Fee: \$1,153.60	<b>Benefit:</b> 75% = \$865.20	85% = \$1068.90
	10:01 HOURS TO 10	:10 HOURS (57 basic u	units)
23530	<b>Fee:</b> \$1,174.20	<b>Benefit:</b> 75% = \$880.65	85% = \$1089.50
23330		:20 HOURS (58 basic 1	
22540		,	
23540		Benefit: 75% = \$896.10 :30 HOURS (59 basic ı	
	10.21 HOURS 10 10	.50 1100KS (59 basic (	lints)
23550		<b>Benefit:</b> 75% = \$911.55	
	10:31 HOURS TO 10	:40 HOURS (60 basic ı	inits)
23560	Fee: \$1,236.00	<b>Benefit:</b> 75% = \$927.00	85% = \$1151.30
	10:41 HOURS TO 10	:50 HOURS (61 basic u	units)
23570	Fee: \$1,256.60	<b>Benefit:</b> 75% = \$942.45	85% = \$1171.90
	10:51 HOURS TO 11	:00 HOURS (62 basic u	inits)
23580	Fee: \$1,277.20	<b>Benefit:</b> 75% = \$957.90	85% = \$1192.50
		:10 HOURS (63 basic u	
23590	Fee: \$1,297.80	<b>Benefit:</b> 75% = \$973.35	85% - \$1213.10
25570		20  HOURS (64 basic  1)	
		× ×	
23600		<b>Benefit:</b> 75% = \$988.80	85% = \$1233.70
	11:21 HOURS TO 11:30 HOURS (65 basic units)		inits)
23610	Fee: \$1,339.00	<b>Benefit:</b> 75% = \$1004.25	85% = \$1254.30

ANAEST	ATIVE VALUE GUIDE FOR HESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA	
PERFOR	MED IN ASSOCIATION WITH AN	
ELIGIBL	E SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
	11:31 HOURS TO 11:40 HOURS (66 basic units)	
23620	<b>Fee:</b> \$1,359.60 <b>Benefit:</b> 75% = \$1019.70 85% =	= \$1274.90
	11:41 HOURS TO 11:50 HOURS (67 basic units)	
23630	<b>Fee:</b> \$1,380.20 <b>Benefit:</b> 75% = \$1035.15 85% =	= \$1295.50
	11:51 HOURS TO 12:00 HOURS (68 basic units)	
23640	<b>Fee:</b> \$1,400.80 <b>Benefit:</b> 75% = \$1050.60 85% =	= \$1316.10
	12:01 HOURS TO 12:10 HOURS (69 basic units)	
23650	<b>Fee:</b> \$1,421.40 <b>Benefit:</b> 75% = \$1066.05 85% =	= \$1336.70
	12:11 HOURS TO 12:20 HOURS (70 basic units)	
23660	<b>Fee:</b> \$1,442.00 <b>Benefit:</b> 75% = \$1081.50 85% =	= \$1357.30
	12:21 HOURS TO 12:30 HOURS (71 basic units)	
23670	<b>Fee:</b> \$1,462.60 <b>Benefit:</b> 75% = \$1096.95 85% =	= \$1377.90
	12:31 HOURS TO 12:40 HOURS (72 basic units)	
23680	<b>Fee:</b> \$1,483.20 <b>Benefit:</b> 75% = \$1112.40 85% =	= \$1398.50
	12:41 HOURS TO 12:50 HOURS (73 basic units)	
23690	<b>Fee:</b> \$1,503.80 <b>Benefit:</b> 75% = \$1127.85 85% =	= \$1419.10
23090	12:51 HOURS TO 13:00 HOURS (74 basic units)	÷
23700	<b>Fee:</b> \$1,524.40 <b>Benefit:</b> 75% = \$1143.30 85% =	- \$1420.70
23700	<b>Fee:</b> $51,524.40$ <b>Benefit:</b> $75\% = 51145.50$ $85\% = 13:01$ HOURS TO 13:10 HOURS (75 basic units)	= \$1439.70
22510		\$1470.20
23710	Fee: \$1,545.00         Benefit: 75% = \$1158.75         85% =           13:11 HOURS TO 13:20 HOURS (76 basic units)	= \$1460.30
23720	Fee:         \$1,565.60         Benefit:         75% = \$1174.20         85% =           12.21         101 IDS TO 12.20         101 IDS (77 h - 1)         101 IDS (77 h - 1	= \$1480.90
	13:21 HOURS TO 13:30 HOURS (77 basic units)	
23730	<b>Fee:</b> \$1,586.20 <b>Benefit:</b> 75% = \$1189.65 85% =	= \$1501.50
	13:31 HOURS TO 13:40 HOURS (78 basic units)	
23740	Fee: \$1,606.80         Benefit: 75% = \$1205.10         85% =	= \$1522.10
	13:41 HOURS TO 13:50 HOURS (79 basic units)	
23750	<b>Fee:</b> \$1,627.40 <b>Benefit:</b> 75% = \$1220.55 85% =	= \$1542.70
	13:51 HOURS TO 14:00 HOURS (80 basic units)	
23760	<b>Fee:</b> \$1,648.00 <b>Benefit:</b> 75% = \$1236.00 85% =	= \$1563.30

T10. RELATIVE VALUE GUIDE FOR			
-	ANAESTHESIA - MEDICARE BENEFITS ARE		
	AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN		
		ESTHESIA/PERFUSION TIME UNITS	
	14:01 HOURS TO 14:10 HOURS (81 basic units)		
23770	<b>Fee:</b> \$1,668.60 <b>Benefit:</b> 75% = \$1251.45 85% = \$1583.90	)	
	14:11 HOURS TO 14:20 HOURS (82 basic units)		
23780	<b>Fee:</b> \$1,689.20 <b>Benefit:</b> 75% = \$1266.90 85% = \$1604.50	)	
	14:21 HOURS TO 14:30 HOURS (83 basic units)		
23790	<b>Fee:</b> \$1,709.80 <b>Benefit:</b> 75% = \$1282.35 85% = \$1625.10	)	
	14:31 HOURS TO 14:40 HOURS (84 basic units)		
23800	<b>Fee:</b> \$1,730.40 <b>Benefit:</b> 75% = \$1297.80 85% = \$1645.70	)	
	14:41 HOURS TO 14:50 HOURS (85 basic units)		
23810	<b>Fee:</b> \$1,751.00 <b>Benefit:</b> 75% = \$1313.25 85% = \$1666.30	)	
	14:51 HOURS TO 15:00 HOURS (86 basic units)		
23820	<b>Fee:</b> \$1,771.60 <b>Benefit:</b> 75% = \$1328.70 85% = \$1686.90	)	
	15:01 HOURS TO 15:10 HOURS (87 basic units)		
23830	<b>Fee:</b> \$1,792.20 <b>Benefit:</b> 75% = \$1344.15 85% = \$1707.50	)	
	15:11 HOURS TO 15:20 HOURS (88 basic units)		
23840	<b>Fee:</b> \$1,812.80 <b>Benefit:</b> 75% = \$1359.60 85% = \$1728.10	)	
	15:21 HOURS TO 15:30 HOURS (89 basic units)		
23850	<b>Fee:</b> \$1,833.40 <b>Benefit:</b> 75% = \$1375.05 85% = \$1748.70	)	
	15:31 HOURS TO 15:40 HOURS (90 basic units)		
23860	<b>Fee:</b> \$1,854.00 <b>Benefit:</b> 75% = \$1390.50 85% = \$1769.30	)	
	15:41 HOURS TO 15:50 HOURS (91 basic units)		
23870	<b>Fee:</b> \$1,874.60 <b>Benefit:</b> 75% = \$1405.95 85% = \$1789.90	)	
	15:51 HOURS TO 16:00 HOURS (92 basic units)		
23880	<b>Fee:</b> \$1,895.20 <b>Benefit:</b> 75% = \$1421.40 85% = \$1810.50	)	
	16:01 HOURS TO 16:10 HOURS (93 basic units)		
23890	<b>Fee:</b> \$1,915.80 <b>Benefit:</b> 75% = \$1436.85 85% = \$1831.10	)	
	16:11 HOURS TO 16:20 HOURS (94 basic units)		
23900	<b>Fee:</b> \$1,936.40 <b>Benefit:</b> 75% = \$1452.30 85% = \$1851.70	)	
	16:21 HOURS TO 16:30 HOURS (95 basic units)		
23910	<b>Fee:</b> \$1,957.00 <b>Benefit:</b> 75% = \$1467.75 85% = \$1872.30	)	

T10 RF	LATIVE VALUE GUIDE FOR	
ANAES	THESIA - MEDICARE BENEFITS ARE	
-	AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN	
	LE SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
	16:31 HOURS TO 16:40 HOURS (96 basic un	its)
23920	<b>Fee:</b> \$1,977.60 <b>Benefit:</b> 75% = \$1483.20	85% = \$1892.90
	16:41 HOURS TO 16:50 HOURS (97 basic un	its)
23930	<b>Fee:</b> \$1,998.20 <b>Benefit:</b> 75% = \$1498.65	85% = \$1913.50
	16:51 HOURS TO 17:00 HOURS (98 basic un	its)
23940	<b>Fee:</b> \$2,018.80 <b>Benefit:</b> 75% = \$1514.10	85% = \$1934.10
	17:01 HOURS TO 17:10 HOURS (99 basic un	its)
23950	<b>Fee:</b> \$2,039.40 <b>Benefit:</b> 75% = \$1529.55	85% = \$1954.70
	17:11 HOURS TO 17:20 HOURS (100 basic u	nits)
23960	<b>Fee:</b> \$2,060.00 <b>Benefit:</b> 75% = \$1545.00	85% = \$1975.30
	17:21 HOURS TO 17:30 HOURS (101 basic u	nits)
23970	<b>Fee:</b> \$2,080.60 <b>Benefit:</b> 75% = \$1560.45	85% = \$1995.90
	17:31 HOURS TO 17:40 HOURS (102 basic u	nits)
23980	<b>Fee:</b> \$2,101.20 <b>Benefit:</b> 75% = \$1575.90	85% = \$2016.50
	17:41 HOURS TO 17:50 HOURS (103 basic u	nits)
23990	<b>Fee:</b> \$2,121.80 <b>Benefit:</b> 75% = \$1591.35	85% = \$2037.10
	17:51 HOURS TO 18:00 HOURS (104 basic u	nits)
24100	<b>Fee:</b> \$2,142.40 <b>Benefit:</b> 75% = \$1606.80	85% = \$2057.70
	18:01 HOURS TO 18:10 HOURS (105 basic u	nits)
24101	<b>Fee:</b> \$2,163.00 <b>Benefit:</b> 75% = \$1622.25	85% = \$2078.30
	18:11 HOURS TO 18:20 HOURS (106 basic u	nits)
24102	<b>Fee:</b> \$2,183.60 <b>Benefit:</b> 75% = \$1637.70	85% = \$2098.90
	18:21 HOURS TO 18:30 HOURS (107 basic u	nits)
24103	<b>Fee:</b> \$2,204.20 <b>Benefit:</b> 75% = \$1653.15	85% = \$2119.50
	18:31 HOURS TO 18:40 HOURS (108 basic u	nits)
24104	<b>Fee:</b> \$2,224.80 <b>Benefit:</b> 75% = \$1668.60	85% = \$2140.10
	18:41 HOURS TO 18:50 HOURS (109 basic u	
24105	<b>Fee:</b> \$2,245.40 <b>Benefit:</b> 75% = \$1684.05	85% = \$2160.70
	18:51 HOURS TO 19:00 HOURS (110 basic u	
24106	<b>Fee:</b> \$2,266.00 <b>Benefit:</b> 75% = \$1699.50	85% = \$2181.30

T10. RELATIVE VALUE GUIDE FOR			
	ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA		
	RMED IN ASSOCIATION WITH AN LE SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS	
	19:01 HOURS TO 19:10 HOURS (111 basic units)		
24107	<b>Fee:</b> \$2,286.60 <b>Benefit:</b> 75% = \$1714.95 85% =	\$2201.90	
	19:11 HOURS TO 19:20 HOURS (112 basic units)		
24108	<b>Fee:</b> \$2,307.20 <b>Benefit:</b> 75% = \$1730.40 85% =	\$2222.50	
	19:21 HOURS TO 19:30 HOURS (113 basic units)		
24109	<b>Fee:</b> \$2,327.80 <b>Benefit:</b> 75% = \$1745.85 85% =	\$2243.10	
	19:31 HOURS TO 19:40 HOURS (114 basic units)		
24110	<b>Fee:</b> \$2,348.40 <b>Benefit:</b> 75% = \$1761.30 85% =	\$2263.70	
	19:41 HOURS TO 19:50 HOURS (115 basic units)		
24111	<b>Fee:</b> \$2,369.00 <b>Benefit:</b> 75% = \$1776.75 85% =	\$2284.30	
	19:51 HOURS TO 20:00 HOURS (116 basic units)		
24112	<b>Fee:</b> \$2,389.60 <b>Benefit:</b> 75% = \$1792.20 85% =	\$2304.90	
	20:01 HOURS TO 20:10 HOURS (117 basic units)		
24113	<b>Fee:</b> \$2,410.20 <b>Benefit:</b> 75% = \$1807.65 85% =	\$2325.50	
	20:11 HOURS TO 20:20 HOURS (118 basic units)		
24114	<b>Fee:</b> \$2,430.80 <b>Benefit:</b> 75% = \$1823.10 85% =	\$2346.10	
	20:21 HOURS TO 20:30 HOURS (119 basic units)		
24115	<b>Fee:</b> \$2,451.40 <b>Benefit:</b> 75% = \$1838.55 85% =	\$2366.70	
	20:31 HOURS TO 20:40 HOURS (120 basic units)		
24116	<b>Fee:</b> \$2,472.00 <b>Benefit:</b> 75% = \$1854.00 85% =	\$2387.30	
	20:41 HOURS TO 20:50 HOURS (121 basic units)		
24117	<b>Fee:</b> \$2,492.60 <b>Benefit:</b> 75% = \$1869.45 85% =	\$2407.90	
	20:51 HOURS TO 21:00 HOURS (122 basic units)		
24118	<b>Fee:</b> \$2,513.20 <b>Benefit:</b> 75% = \$1884.90 85% =	\$2428.50	
	21:01 HOURS TO 21:10 HOURS (123 basic units)		
24119	<b>Fee:</b> \$2,533.80 <b>Benefit:</b> 75% = \$1900.35 85% =	\$2449.10	
	21:11 HOURS TO 21:20 HOURS (124 basic units)		
24120	<b>Fee:</b> \$2,554.40 <b>Benefit:</b> 75% = \$1915.80 85% =	\$2469.70	
-	21:21 HOURS TO 21:30 HOURS (125 basic units)		
24121	<b>Fee:</b> \$2,575.00 <b>Benefit:</b> 75% = \$1931.25 85% =	\$2490.30	

T10. REI	ATIVE VALUE GUIDE FOR	
ANAESTHESIA - MEDICARE BENEFITS ARE		
	AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN	
	E SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
	21:31 HOURS TO 21:40 HOURS (126 basic up	nits)
24122	<b>Fee:</b> \$2,595.60 <b>Benefit:</b> 75% = \$1946.70	85% = \$2510.90
	21:41 HOURS TO 21:50 HOURS (127 basic up	nits)
24123	<b>Fee:</b> \$2,616.20 <b>Benefit:</b> 75% = \$1962.15	85% = \$2531.50
	21:51 HOURS TO 22:00 HOURS (128 basic up	nits)
24124	<b>Fee:</b> \$2,636.80 <b>Benefit:</b> 75% = \$1977.60	85% = \$2552.10
	22:01 HOURS TO 22:10 HOURS (129 basic un	nits)
24125	<b>Fee:</b> \$2,657.40 <b>Benefit:</b> 75% = \$1993.05	85% = \$2572.70
	22:11 HOURS TO 22:20 HOURS (130 basic un	nits)
24126	<b>Fee:</b> \$2,678.00 <b>Benefit:</b> 75% = \$2008.50	85% = \$2593.30
21120	22:21 HOURS TO 22:30 HOURS (131 basic up	
24127	<b>Fee:</b> \$2,698.60 <b>Benefit:</b> 75% = \$2023.95	85% = \$2613.90
	22:31 HOURS TO 22:40 HOURS (132 basic u	
24128	<b>Fee:</b> \$2,719.20 <b>Benefit:</b> 75% = \$2039.40	85% = \$2634.50
21120	22:41 HOURS TO 22:50 HOURS (133 basic un	
24129	<b>Fee:</b> \$2,739.80 <b>Benefit:</b> 75% = \$2054.85	85% - \$2655.10
2712)	22:51 HOURS TO 23:00 HOURS (134 basic u	
24120		, ,
24130	Fee: \$2,760.40         Benefit: 75% = \$2070.30           23:01 HOURS TO 23:10 HOURS (135 basic units)	· · ·
24131	Fee:         \$2,781.00         Benefit:         75%         \$2085.75	
	23:11 HOURS TO 23:20 HOURS (136 basic un	nits)
24132	<b>Fee:</b> \$2,801.60 <b>Benefit:</b> 75% = \$2101.20	85% = \$2716.90
	23:21 HOURS TO 23:30 HOURS (137 basic un	nits)
24133	<b>Fee:</b> \$2,822.20 <b>Benefit:</b> 75% = \$2116.65	85% = \$2737.50
	23:31 HOURS TO 23:40 HOURS (138 basic up	nits)
24134	<b>Fee:</b> \$2,842.80 <b>Benefit:</b> 75% = \$2132.10	85% = \$2758.10
	23:41 HOURS TO 23:50 HOURS (139 basic up	nits)
24135	<b>Fee:</b> \$2,863.40 <b>Benefit:</b> 75% = \$2147.55	85% = \$2778.70
	23:51 HOURS TO 24:00 HOURS (140 basic u	
24136	<b>Fee:</b> \$2,884.00 <b>Benefit:</b> 75% = \$2163.00	85% = \$2799.30
_ 1100	<b>Denema</b> 7570 - \$2105.00	ουτο φ=τ///ου

#### 22. ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	Subgroup 22. Anaesthesia/Perfusion Modifying Units - Physical Status		
	ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA		
	(a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or		
	(b) for perfusion performed in association with item 22060; or		
	(c) for assistance at anaesthesia performed in association with items 25200 to 25205		
	Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units)		
25000	(See para TN.10.3 of explanatory notes to this Category)Fee: $$20.60$ Benefit: $75\% = $15.45$ $85\% = $17.55$		
	Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units)		
25005	(See para TN.10.3 of explanatory notes to this Category)Fee: $$41.20$ Benefit: $75\% = $30.90$ $85\% = $35.05$		
	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: $$61.80$ Benefit: $75\% = $46.35$ $85\% = $52.55$		
ANAES ONLY F PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN 23. ANAESTHESIA/PERFUSION MODIFYING LE 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)		
25013 S Fee: \$20.60 Benefit: 75% = \$15.45 85% = \$17.55			
_	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more (Anaes.) (1 basic units)		
25014 S	<b>Fee:</b> \$20.60 <b>Benefit:</b> 75% = \$15.45 85% = \$17.55		
25020	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA		

T10. RELATIVE VALUE GUIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
ONLY PAYABLE FOR ANAESTHESIA
PERFORMED IN ASSOCIATION WITH AN
ELIGIBLE SERVICE

#### 23. ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER

- 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:** \$41.20 **Benefit:** 75% = \$30.90 85% = \$35.05

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

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## 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) <b>Derived Fee:</b> 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)
25030	(See para TN.10.3 of explanatory notes to this Category) <b>Derived Fee:</b> 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 (d) where performed, any associated therapeutic or diagnostic service 22002 -22051
ANAES ONLY P PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN 25. PERFUSION AFTER HOURS EMERGENCY LE SERVICE MODIFIEF
	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
25050	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 weekday or on a Saturday, Sunday or public holiday. (0 basic units)

25050

ANAEST ONLY P PERFOR	ATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA MED IN ASSOCIATION WITH AN 25. PERFUSION AFTER HOURS EMERGENCY E SERVICE MODIFIER		
	(See para TN.10.3 of explanatory notes to this Category) <b>Derived Fee:</b> An additional amount of 50% of the fee for the 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, any associated therapeutic or diagnostic service in the range 22002-22051 or 22065-22075		
ANAEST ONLY P PERFOR	T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE 26. ASSISTANCE AT ANAESTHESIA		
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	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)		
<b>Fee</b> 25200	(See para TN.10.9 of explanatory notes to this Category) <b>Derived Fee:</b> An amount of \$103.00 (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)

(See para TN.10.9 of explanatory notes to this Category)

Derived Fee: An amount of \$103.00 (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 25205 range 22001 - 22051

# **T11. BOTULINUM TOXIN INJECTIONS**

Fee

	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	
<b>Fee</b> 18350	(See para TN.11.1 of explanatory notes to this Category)           Fee: \$129.90         Benefit: 75% = \$97.45         85% = \$110.45	

T11. BC	. BOTULINUM TOXIN INJECTIONS	
	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	
<b>Fee</b> 18351	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$129.90 <b>Benefit:</b> 75% = \$97.45 85% = \$110.45	
	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	
<b>Fee</b> 18353	(See para TN.11.1 of explanatory notes to this Category)         Fee: \$259.85       Benefit: 75% = \$194.90       85% = \$220.90	
	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.)	
<b>Fee</b> 18354	(See para TN.11.1 of explanatory notes to this Category) <b>Benefit:</b> $75\% = \$97.45$ $85\% = \$110.45$	
	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	
<b>Fee</b> 18360	(See para TN.11.1 of explanatory notes to this Category)           Fee: \$129.90         Benefit: 75% = \$97.45         85% = \$110.45	
	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>Fee</b> 18361	(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	

T11. BO	TULINUM TOXIN INJECTIONS
	2 sets of injections for each upper limb), including all injections per set (Anaes.)
	(See para TN.11.1 of explanatory notes to this Category)           Fee: \$129.90         Benefit: 75% = \$97.45         85% = \$110.45
	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
	(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.)
<b>Fee</b> 18362	(See para TN.11.1 of explanatory notes to this Category)         Fee: \$256.70       Benefit: 75% = \$192.55       85% = \$218.20
	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
<b>Fee</b> 18365	(See para TN.11.1 of explanatory notes to this Category)           Fee: \$129.90         Benefit: 75% = \$97.45         85% = \$110.45
	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.)
<b>Fee</b> 18366	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$162.75 <b>Benefit:</b> 75% = \$122.10 85% = \$138.35
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day
<b>Fee</b> 18368	(See para TN.11.1 of explanatory notes to this Category)Fee: $$277.85$ Benefit: $75\% = $208.40$ $85\% = $236.20$
Fee 18369	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA

T11. BO	TULINUM TOXIN INJECTIONS
	(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.)
	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$46.85 <b>Benefit:</b> 75% = \$35.15 85% = \$39.85
	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.)
<b>Fee</b> 18370	(See para TN.11.1 of explanatory notes to this Category)           Fee: \$46.85         Benefit: 75% = \$35.15         85% = \$39.85
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day (Anaes.)
<b>Fee</b> 18372	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$129.90 <b>Benefit:</b> 75% = \$97.45 85% = \$110.45
	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.)
<b>Fee</b> 18374	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$129.90 <b>Benefit:</b> 75% = \$97.45 85% = \$110.45
	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
<b>Fee</b> 18375	(c) the patient is willing and able to self-catheterise; and

T11. BOT	ULINUM TOXIN INJECTIONS
	(d) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with; and
	(e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919
	For each patient - applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.)
	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$239.20 <b>Benefit:</b> 75% = \$179.40
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in 1 day, if:
	(a) the patient is at least 18 years of age; and
	(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)
<b>Fee</b> 18377	(See para TN.11.1 of explanatory notes to this Category)           Fee: \$129.90         Benefit: 75% = \$97.45         85% = \$110.45
	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 idiopathic overactive bladder in a patient: and
	(b) the patient is at least 18 years of age; and
	(c) the patient has urinary incontinence that is inadequately controlled by at least 2 alternative anti-
	cholinergic agents, as manifested by having experienced at least 14 episodes of urinary incontinence per week
	before commencement of treatment with botulinum toxin; and
<b>Fee</b> 18379	(d) the patient is willing and able to self-catheterise; and

(e) treatment is not provided on the same occasion as a service mentioned in item 104, 105, 110, 116, 119, 11900 or 11919
For each patient-applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment
(H) (Anaes.)
(See para TN.11.1 of explanatory notes to this Category)
<b>Fee:</b> \$239.20 <b>Benefit:</b> 75% = \$179.40

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30045, 30049         traumatic, suture of       30026, 30029, 30032,         30042, 30045, 30049         Treacher Collins Syndrome, peri-orbital correction of         treatment of including paediatric       50600,         50612, 50616, 50620, 50624, 50628, 50632, 5063         50644, 50650, 50654, 50658         treatment of paediatric	30035, of 50604, 6, 50640 50508,	30038 45773 50608 0 50512
30045, 30049         traumatic, suture of       30026, 30029, 30032,         30042, 30045, 30049         Treacher Collins Syndrome, peri-orbital correction of         treatment of including paediatric       50600,         50612, 50616, 50620, 50624, 50628, 50632, 5063         50644, 50650, 50654, 50658         treatment of paediatric         treatment, eye       42782, 42785, 42788,	30035, of 50604, 6, 50640 50508,	30038 45773 50608 0 50512
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30045, 30049         traumatic, suture of       30026, 30029, 30032,         30042, 30045, 30049         Treacher Collins Syndrome, peri-orbital correction of         treatment of including paediatric       50600,         50612, 50616, 50620, 50624, 50628, 50632, 5063         50644, 50650, 50654, 50658         treatment of paediatric         treatment, eye       42782, 42785, 42788,         42801-42802, 42805-42806         Trephine of frontal sinus         Trichiasis, treatment of	30035, f 50604, 6, 50644 50508, 42791, 42587-	30038 45773 50608 0 50512 42794 41743 42588
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