Australian Government Department of Health

Medicare Benefits Schedule Book Category 3 Operating from 1 March 2020

Title: Medicare Benefits Schedule Book

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

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

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GENERAL EXPLANATORY NOTES

GENERAL EXPLANATORY NOTES

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

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

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

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
 - a copy of their personal details in their passport and all Australian visas and entry stamps; and
 a letter from the employer stating why the person requires a Medicare provider number and/or
 prescriber number is required; and
 - iv. a copy of the employment contract.

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

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

Medicare

GPO Box 9822

in your capital city

or

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

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

MBS Interpretations

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

or by phone on 132 150

GN.3.9 Patient eligibility for Medicare

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

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

GN.3.10 Medicare cards

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

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

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

GN.3.11 Visitors to Australia and temporary residents

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

GN.3.12 Reciprocal Health Care Agreements

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

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

Exceptions:

 \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
- · 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>gicpd@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: www.humanservices.gov.au. Applicants should forward their applications, as appropriate, to

The Secretariat

The General Practice Recognition Eligibility Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprec@health.gov.au

The Secretariat

The General Practice Recognition Appeal Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprac@health.gov.au

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

Continued vocational recognition is dependent upon:

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

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

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

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

Removal of vocational recognition status

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

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

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

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

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

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

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

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

A medical practitioner who is training for a fellowship of a specified specialist College and is undertaking training placements in a private hospital or in general practice, may provide services which attract Medicare rebates. Specialist trainees should consult the information available at the <u>Department of Human Services' Medicare</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.6.16 Referral Of Patients To Specialists Or Consultant Physicians

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

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

What is a Referral?

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

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

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

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

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

The exceptions to the requirements in paragraph above are that

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

- a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);

(b) sub-paragraphs (ii) and (iii) do not apply to

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

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

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

Examination by Specialist Anaesthetists

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

Who can Refer?

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

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

For Medicare benefit purposes, a referral may be made to

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

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

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

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

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

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

Billing

Routine Referrals

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

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

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

Special Circumstances

(i) Lost, stolen or destroyed referrals.

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

(ii) Emergencies

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

(iii) Hospital referrals.

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

Public Hospital Patients

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

Bulk Billing

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

Period for which Referral is Valid

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

Specialist Referrals

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

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

Referrals by other Practitioners

Where the referral originates from a practitioner other than those listed in *Specialist Referrals*, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific 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 2020 is \$477.90. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

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

In 2020, the threshold for singles and families that hold a Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB (A) is \$692.20. The threshold for all other singles and families in 2019 is \$2,169.20.

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

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

EMSN Benefit Caps:

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

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

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

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

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

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

GN.11.28 Services not listed in the MBS

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

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

GN.11.29 Ministerial Determinations

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

GN.12.30 Professional services

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

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

(a) Category 1 (Professional Attendances) items except 170-172, 342-346, 820-880, 6029–6042, 6064-6075;

(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11304, 11600, 11627, 11701, 11712, 11722, 11724, 11728, 11921, 12000, 12003;

(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14245);

(d) Item 15600 in Group T2 (Radiation Oncology);

(e) All Group T3 (Therapeutic Nuclear Medicine) items;

- (f) All Group T4 (Obstetrics) items (except 16400 and 16514);
- (g) All Group T6 (Anaesthetics) items;
- (h) All Group T7 (Regional or Field Nerve Block) items;
- (i) All Group T8 (Operations) items;
- (j) All Group T9 (Assistance at Operations) items;
- (k) All Group T10 (Relative Value Guide for Anaesthetics) items.

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

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

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

GN.12.31 Services rendered on behalf of medical practitioners

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

(a) the medical practitioner in whose name the service is being claimed;

(b) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

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

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

Supervision from outside of Australia is not acceptable.

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

(a) established consistent quality assurance procedures for the data acquisition; and

(b) personally analysed the data and written the report.

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

GN.12.32 Medicare benefits and vaccinations

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

Example 1

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

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

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

Example 2

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

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

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

Example 3

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

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

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

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

(a) telephone consultations;

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

(d) non-therapeutic cosmetic surgery;

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

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

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

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

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

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

Unless the Minister otherwise directs

Medicare benefits are not payable where:

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

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

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

(d) the service is a health screening service.

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

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

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

(b) the injection of human chorionic gonadotrophin in the management of obesity;

- (c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
- (d) the removal of tattoos;

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

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

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

Pain pumps for post-operative pain management

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

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

Non Medicare Services

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

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

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

(a) endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;

(b) gamma knife surgery;

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

- (g) lung volume reduction surgery, for advanced emphysema;
- (h) photodynamic therapy, for skin and mucosal cancer;
- (i) placement of artificial bowel sphincters, in the management of faecal incontinence;

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

- (k) specific mass measurement of bone alkaline phosphatase;
- (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 01/03/2020

The 01/03/2020 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

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

Deleted Items

13847 14200

New Items

13832	13834	13835	13837	13838	13840	13899	14255	14256	14257	14258	14259	14260
14263	14264	14265	14266	14270	14272	14277	14278	14280	14283	14285	14288	

Description Amended

13815 13842 13848 13851 13854 41501

Fee Amended

13815 13842 13848

Minor amendment to stroboscopy item 41501 to also refer to malignant vocal fold lesions

THERAPEUTIC PROCEDURES NOTES

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

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

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

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

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

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

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

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

(c) is staffed by:

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

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

(d) has admission and discharge policies in operation.

TN.1.2 Haemodialysis - (Items 13100 and 13103)

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

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

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

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

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

(generally monthly);

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.1.5 Intracytoplasmic Sperm Injection - (Item 13251)

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

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

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

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

TN.1.6 Peripherally Inserted Central Catheters

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

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

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

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

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

TN.1.8 Collection of Blood - (Item 13709)

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

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

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

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

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

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

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

- (iii) a registered nurse for at least 18 hours in each day; and
- (c) has defined admission and discharge policies.

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

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

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

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

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

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

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

(c) has defined admission and discharge policies.

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

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

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

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

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

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

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

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

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

Items 13847 and 13848

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

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

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

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

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

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

Items 13870 and 13873

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

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

Item 13876

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

Item 11600

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

TN.1.12 Cytotoxic Chemotherapy Administration - (Item 13915)

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

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

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

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

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

Phototherapy should only be used when:

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

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

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

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

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

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

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

Entire forehead	50-75 cm ²

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

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

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

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

Items 14203 and 14206 are not payable for artificial insemination.

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

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

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

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

TN.1.19 Immunomodulating Agent - (Item 14245)

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

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

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

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

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

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

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

TN.1.21 Telehealth Specialist Services

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

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

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

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

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

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

Referrals

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

Technical requirements

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

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

TN.1.22 Cryopreservation of semen (Item 13260)

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

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

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

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

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

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

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

TN.2.1 Radiation Oncology - General

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

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

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

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

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

In items 15275, 15555, 15565 and 15715:

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

In item 15275:

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

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

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

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

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

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

A planning episode involves field setting and dosimetry. One plan only will attract Medicare benefits in a course of treatment. However, benefits are payable for 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.6.1 Pre-anaesthesia Consultations by an Anaesthetist - (Items 17610 to 17625)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• 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 service 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.

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

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

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

TN.8.5 Abandoned surgery - (Item 30001)

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

An operative procedure commences when:

a) The patient is in the procedure room or on the bed or operation table where the procedure is to be performed; and

b) The patient is anaesthetised or operative site is sufficiently anaesthetised for the procedure to commence; and

c) The patient is positioned or the operative site which is prepared with antiseptic or draping.

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

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

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

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

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

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

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

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

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

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

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

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

TN.8.8 Lipectomy - (Items 30165 to 30179)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Anatomically, the dissection extends from below upwards as follows:

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

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

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

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

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

TN.8.16 Major Abdominal Incision - (Item 30396)

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

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

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

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

Cleaning, disinfection and sterilisation procedures

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

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

Anaesthetic and resuscitation equipment

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

Conjoint Committee

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

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

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

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

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

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

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

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

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

For the purposes of these items the following definitions apply:

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

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

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

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

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

- A patient with biochemical evidence of a neuroendocrine tumour.

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

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

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

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

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

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

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

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

TN.8.23 Removal of Skin Lesion From Face - (Items 31245, 31361 to 31364, 31372 and 31373) For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Items 31569 to 31581 and item 20791 provide for surgical treatment of clinically severe obesity and the accompanying anaesthesia service (or similar). The term clinically severe obesity generally refers to a patient with a Body Mass Index (BMI) of 40kg/m² or more, or a patient with a BMI of 35kg/m² 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 $35-40 \text{ kg/m}^2$ provided for in the definition. The decision to undertake obesity surgery remains a matter for the clinical judgment of the surgeon.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.8.34 Uterine Artery Embolisation - (Item 35410)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.8.42 Colposcopic Examination - (Item 35614)

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

(a) where the patient has had an abnormal cervical screen result;

(b) where there is a history of ingestion of oestrogen by the patient's mother during their pregnancy; or

(c) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

TN.8.43 Hysteroscopy - (Item 35626)

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

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

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

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

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

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

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

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

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

TN.8.47 Debulking of Uterus - (Item 35658)

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

TN.8.48 Nephrectomy - (Items 36526 and 36527)

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

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

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

TN.8.51 Ureteroscopy - (Item 36803)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.8.58 Transcutaneous Sperm Retrieval - (Item 37605)

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

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

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

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

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

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

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

TN.8.60 Cardiac Pacemaker Insertion - (Items 38209, 38212, 38350, 38353 and 38356)

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

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

TN.8.61 Implantable ECG Loop Recorder - (Item 38285)

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

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

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;

- electrocardiography (ECG) (items 1170-11702);
- echocardiography (items 55113-55115);
- continuous ECG recording or ambulatory ECG monitoring (items 11708-11711);
- up-right tilt table test (item 11724); and

- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

TN.8.62 Transluminal Insertion of Stent or Stents - (Item 38306)

Item 38306 should only be billed once per occlusional site. It is not appropriate to bill item 38306 multiple times for the insertion of more than one stent at the same occlusional site in the same artery. However, it would be appropriate to claim this item multiple times for insertion of stents into the same artery at different occlusional sites or into

another artery or occlusional site. It is expected that the practitioner will note the details of the artery or site into which the stents were placed, in order for the Department of Human Services to process the claims.

TN.8.63 Permanent Cardiac Synchronisation Device (Items 38365, 38368 and 38654)

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

TN.8.64 Intravascular Extraction of Permanent Pacing Leads - (Item 38358)

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

TN.8.65 Cardiac Resynchronisation Therapy - (Item 38371)

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

TN.8.66 Implantable Cardioverter Defibrillator - (Items 38384 and 38387)

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

TN.8.67 Cardiac and Thoracic Surgical Items - (Items 38470 to 38766)

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

TN.8.68 Coronary Artery Bypass - (Items 38497 to 38504)

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

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

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

TN.8.69 Re-operation via Median Sternotomy - (Item 38640)

Medicare benefits are payable for Item 38640 plus the item/s covering the major surgical procedure/s performed at the time of the re-operation, using the multiple operation formula. Benefits are not payable for Item 38640 in association with Item 38656, 38643 or 38647.

TN.8.70 Skull Base Surgery - (Items 39640 to 39662)

The surgical management of lesions involving the skull base (base of anterior, middle and posterior fossae) often requires the skills of several surgeons or a number of surgeons from different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of the dura, subcutaneous tissues, and skin to avoid serious infections such as osteomyelitis and/or meningitis.

Items 39640 to 39662 cover the removal of the tumour, which would normally be performed by a neurosurgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as ENT and plastic and reconstructive surgery.

TN.8.71 Intradiscal Injection of Chymopapain - (Item 40336)

The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

TN.8.72 Removal of Ventilating Tube from Ear - (Item 41500)

Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.

TN.8.73 Meatoplasty - (Item 41515)

When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

TN.8.74 Reconstruction of Auditory Canal - (Item 41524)

When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

TN.8.75 Removal of Nasal Polyp or Polypi - (Items 41662 and 41668)

Where such polyps are removed in association with another intranasal procedure, Medicare benefit is paid under Item 41662. However where the associated procedure is of lesser value than Item 41668, benefit for removal of polypi would be paid under Item 41668.

Services performed under item 41668 require admission to hospital.

TN.8.76 Larynx, Direct Examination - (Item 41501)

Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

TN.8.77 Microlaryngoscopy - (Item 41858)

This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

TN.8.78 Imbedded Foreign Body - (Item 42644)

For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.

Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.

Where the imbedded foreign body is not completely removed, benefits are payable under the relevant attendance item.

TN.8.79 Corneal Incisions - (Item 42672)

The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

TN.8.80 Cataract surgery (Items 42698 and 42701)

Items 42698 and 42701 provide for intraocular lens extraction and replacement as a separate procedure to be used in instances when lens removal and replacements are contraindicated at the same operation, such as in patients presenting with proliferative diabetic retinopathy or recurrent uveitis.

TN.8.81 Posterior Juxtascleral Depot injection - (Item 42741)

For the purpose of item 42741, the therapeutic substance must be registered with the Therapeutic Goods Administration (or listed on the Pharmaceutical Benefits Schedule, if so listed) as being suitable for injection for the treatment of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation due to age-related macular degeneration, as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60.

TN.8.82 Cyclodestructive Procedures - (Items 42770)

Item 42770 is restricted to a maximum of 2 treatments in a 2 year period.

TN.8.83 Insertion of drainage device for glaucoma (Item 42752)

Item 42752 provides for the insertion of a drainage device for the treatment of glaucoma patients who are at high risk of failure of trabeculectomy (such as patients who have aggressive neovascular glaucoma or extensive conjunctival scarring); have iridocorneal endothelial syndrome; inflammatory (uveitic) glaucoma; or aphakic glaucoma.

TN.8.84 Laser Trabeculoplasty - (Item 42782)

Item 42782 is restricted to a maximum of 4 treatments in a 2 year period.

TN.8.85 Laser Iridotomy - (Item 42785)

Item 42785 is restricted to a maximum of 3 treatments in a 2 year period.

TN.8.86 Laser Capsulotomy - (Items 42788)

Item 42788 is restricted to a maximum of 2 treatments in a 2 year period.

TN.8.87 Laser Vitreolysis or Corticolysis of Lens Material or Fibrinolysis - (Item 42791)

Item 42791 is restricted to a maximum of 3 treatments in a 2 year period.

TN.8.88 Division of Suture by Laser - (Item 42794)

Benefits under this item are restricted to a maximum of 2 treatments in a 2 year period. There is no provision for additional treatments in that period.

TN.8.89 Ophthalmic Sutures - (Item 42845)

This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning, or adjustment performed prior to the patient leaving the operating theatre.

TN.8.91 Abrasive Therapy/Resurfacing - (Items 45021 to 45026)

For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

Items 45021 and 45024 cover abrasive therapy only. For the purposes of these items, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for benefits under these items.

Items 45025 and 45026 do not cover the use of fractional (Fraxel[®]) laser therapy.

TN.8.92 Escharotomy - (Item 45054)

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

TN.8.93 Local Skin Flap - Definition

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

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

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

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

Note: refer to T8.128 for MBS item 45202 for circumstances where other services might involve flap repair.

TN.8.94 Free Grafting to Burns - (Items 45406 to 45418)

Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

TN.8.95 Revision of Scar - (Items 45506 to 45518)

For the purposes of items 45506 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape of facial aperture.

Items 45506 to 45518 are only claimable when performed by a specialist in the practice of his or her specialty or where undertaken in the operating theatre of a hospital.

Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31206 to 31225 should be claimed.

TN.8.96 Augmentation Mammaplasty - (Items 45524, 45527 and 45528)

A Medicare benefit is generally not attracted under item 45524 unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast sometime after an initial augmentation of one side would not attract benefits. Benefits are not payable for augmentation mammaplasty services performed using fat transfer to the breast.

Item 45528 applies where bilateral mammaplasty is indicated because of malformation of breast tissue, disease or trauma of the breast, (but not as a result of previous cosmetic surgery) other than covered under item 45524 or 45527.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

TN.8.97 Breast Reconstruction, Myocutaneous Flap - (Item 45530)

When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a rectus abdominis flap; item 45569 should be claimed for closure of the abdomen and reconstruction of the umbilicus, and item 45570 may be claimed if repair of the musculoaponeurotic layer is required. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be claimed as it is expected that repair will be by direct suture. In the small number of cases, when a latissimus dorsi flap is used, and repair by means other than direct suture is required, use of item 45203 would be appropriate.

Items 30165-30179 (lipectomy items) should not be claimed in association with item 45530 as stated in the Health Insurance (General Medical Services Table) Regulations.

TN.8.98 Breast Prosthesis, Removal and Replacement of - (Items 45553 and 45554)

It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Medicare benefits are not payable for services under items 45553-45554 where the procedure is performed solely to increase breast size.

Where the original implant was not inserted in the context of breast cancer or developmental abnormality, intraoperative photographs need to demonstrate significant evidence of substantial skin laxity to justify replacement of the prosthesis.

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

Where a rupture has been established through imaging and reported, items 45553 and 45554 will still apply even if intra-operatively the implant is found to be structurally intact.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.99 Breast Ptosis - (Items 45556 and 45558)

For the purposes of item 45556, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, in the context of breast cancer or developmental breast abnormality to match the position of the contralateral breast. This item is payable only once per patient. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

Item 45558 applies where correction of breast ptosis is indicated because at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mammary fold where the nipple is located at the most dependent, inferior part of the breast contour.

Full clinical details must be documented in patient notes, including pre-operative photographic evidence (including anterior, left lateral and right lateral views) as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

TN.8.100 Nipple and/or Areola Reconstruction - (Items 45545 and 45546)

Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

TN.8.101 Liposuction - (Items 45584 and 45585)

Medicare benefits for liposuction are generally attracted under item 45584, that is for the treatment of post-traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would benefits be payable for bilateral liposuction.

Where liposuction is indicated for the treatment of Barraquer-Simons Syndrome, lymphoedema or macrodystrophia lipomatosa, or the reduction of buffalo hump, item 45585 applies. One regional area is defined as one limb or trunk. If liposuction is required on more than one limb, item 45585 can be claimed once per limb.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.102 Meloplasty for Correction of Facial Asymmetry - (Items 45587 and 45588)

Benefits are payable under items 45587 and 45588 for face lift operations performed in hospital to correct soft tissue abnormalities of the face due to causes other than the ageing process, including trauma, a congenital condition or disease.

Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooling from the angles of the mouth and deep pitting of the skin resulting from severe acne scarring, disease or trauma (but not as a result of previous cosmetic surgery), item 45588 applies.

Full clinical details must be documented in patient notes, including pre-operative photographic and/or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.103 Reduction of Eyelids - (Items 45617 and 45620)

Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits.

Medicare benefits are not payable for non-therapeutic cosmetic services. Full clinical details must be documented in patient notes, including clear photographic evidence of the loss of visual field, evidenced by eyelid skin prolapsing over the lashes in a relaxed straight-ahead gaze. The clinical need for the service must be demonstrated as this may be subject to audit.

TN.8.104 Rhinoplasty - (Items 45632 to 45644, and 45650)

Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

A Medicare benefit for items 45632 – 45644 and 45650 is payable where the indication for surgery is for:

(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or

(ii) significant acquired, congenital or developmental deformity.

The NOSE Scale refers to the Nasal Obstruction Symptom Evaluation Scale, developed by Stewart et al, as published in the Otolaryngology-Head and Neck Surgery, 130: 2.

The NOSE Scale can be accessed here: https://www.entnet.org//content/facial-plasticsrhinology-outcome-tool-nose-scale

Full clinical details must be documented in patient notes, including pre-operative photographic and / or NOSE Scale evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.105 Contour Restoration - (Item 45647)

For the purpose of item 45647, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

TN.8.106 Vermilionectomy - (Item 45669)

Item 45669 covers treatment of the entire lip.

TN.8.107 Osteotomy of Jaw - (Items 45720 to 45752)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

For the purposes of these items, a reference to maxilla includes the zygoma.

Item 75621 for the provision of fitting of surgical templates may be claimed in association with the appropriate orthognathic surgical items in the range of 45720 to 45754 for prescribed dental patients registered under the Cleft Lip and Cleft Palate Scheme.

TN.8.108 Genioplasty - (Item 45761)

Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

TN.8.109 Tumour, Cyst, Ulcer or Scar - (Items 45801 to 45813)

It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

TN.8.110 Fracture of Mandible or Maxilla - (Items 45975 to 45996)

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

TN.8.111 Reduction of Dislocation or Fracture

Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

TN.8.112 Removal of Multiple Exostoses (Items 47933 and 47936)

Items 47933 and 47936 provide for removal of multiple exostoses when undertaken via the same incision.

TN.8.116 Wrist Surgery - (Items 49200 to 49227)

For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

TN.8.117 Diagnostic Arthroscopy and Arthroscopic Surgery of the Knee (Items 49557 and 49563)

The Medical Services Advisory Committee (MSAC) evaluated the available evidence and did not support public funding for matrix-induced autologous chondrocyte implantation (MACI) or autologous chondrocyte implantation (ACI) for the treatment of chondral defects in the knee and other joints, due to the increased cost compared to existing procedures and the lack of evidence showing short term or long-term improvements in clinical outcomes. Medicare benefits are not payable in association with this technology.

TN.8.118 Paediatric Patients - (Items 50450 to 50658)

For the purpose of Medicare benefits a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state "with open growth plates").

TN.8.119 Treatment of Fractures in Paediatric Patients - (Items 50500 to 50588)

Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

Medicare benefits are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

TN.8.120 Unresectable primary malignant tumour of the liver destruction of by open or laparoscopic radiofrequency ablation or microwave tissue ablation- (Item 50952)

A multi-disciplinary team for the purposes of item 50952 would include a hepatobilliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

TN.8.121 Paracentesis of anterior chamber or vitreous cavity and/or intravitreal injection - (Items 42738 to 42740)

Items 42738 and 42739 provide for paracentesis for the injection of therapeutic substances and/or the removal of aqueous or vitreous, when undertaken as an independent procedure. That is, not in conjunction with other intraocular surgery.

Item 42739 should be claimed for patients requiring anaesthetic services for the procedure. Advice from the Royal Australian and New Zealand College of Ophthalmologists is that independent injections require only topical

anaesthesia, with or without subconjunctival anaesthesia, except in specific circumstances as outlined below where additional anaesthetic services may be indicated:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.8.126 Flap Repair - (Item 45202)

Practitioners must only perform a muscle or skin flap repair where clinical need can be clearly evidenced (i.e. where a patient hassevere pre-existing scarring, severe skin atrophy, sclerodermoid changes or where the defect is contiguous 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, 32087, 32090 and 32093

If a service to which item 32084, 32087, 32090 or 32093 applies is provided by a practitioner to a patient on more than one occasion on a day, the second service is taken to be a separate service for the purposes of the item if the second service is provided under a second episode of anaesthesia or other sedation.

TN.8.135 Transcatheter Aortic Valve Implantation (Item 38495)

Item 38495 applies only to a service for Transcatheter Aortic Valve Implantation (TAVI) for the treatment of symptomatic severe aortic stenosis, that is to be provided in a TAVI Hospital by a TAVI Practitioner on a TAVI patient.

TAVI Hospital

For item 38495 a TAVI Hospital means a hospital, as defined by subsection 121-5(5) of the Private Health Insurance Act 2007, that is clinically accepted as being a suitable hospital in which the service described in Item 38495 may be performed.

The Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners developed by Cardiac Accreditation Services Limited provides guidance on what are considered by the sector as minimum requirements that must be met in order to be a clinically acceptable facility that is suitable for TAVI procedures to be performed at.

Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners can be accessed via www.tavi.org.au.

TAVI Practitioner

For item 38495 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under item 38495.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules* for the Accreditation of TAVI Practitioners, issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, *www.tavi.org.au*.

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

TAVI Patient

A TAVI Patient means a patient who, as a result of a TAVI Case Conference, has been assessed as having an unacceptably high risk for surgical aortic valve replacement and is recommended as being suitable to receive the service described in item 38495.

A TAVI Case Conference is a process by which:

- (a) there is a team of 3 or more participants, where:
 - (i) the first participant is a cardiothoracic surgeon; and

(ii) the second participant is an interventional cardiologist; and

(iii) the third participant is a specialist or consultant physician who does not perform a service described in Item 38495 for the patient being assessed; and

(iv) either the first or the second participant is also a TAVI Practitioner; and

(b) the team assesses a patient's risk and technical suitability to receive the service described in Item 38495, taking into account matters such as:

- (i) the patient's risk and technical suitability for a surgical aortic valve replacement; and
- (ii) the patient's cognitive function and frailty; and

(c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in Item 38495; and

(d) the particulars of the assessment and recommendation are recorded in writing.

While benefits are payable for an eligible TAVI Case Conference under Items 6080 and 6081, a claim for these services does not have to be made in order for a benefit to be paid under Item 38495. Item 38495 is only payable once per patient in a five year period.

TN.8.136 Corneal Collagen Cross Linking (Item 42652)

Evidence of progression in patients over the age of twenty five is determined by the patient history including an objective change in tomography or refraction over time. Evidence of progression in patients aged twenty five years or younger is determined by patient history including an objective change in tomography or refraction over time and/or posterior elevation data and objective documented progression at a subclinical level.

TN.8.137 Thyroidectomy and hemithyroidectomy procedures (items 30296, 30306, and 30310)

Total thyroidectomy or total hemithyroidectomy are the most appropriate procedures in the majority of circumstances when a thyroidectomy is required. The preferred procedure for thyrotoxicosis is total thyroidectomy (item 30296). Item 30310 is to be used only in uncommon circumstances where a subtotal or partial thyroidectomy is indicated and includes a subtotal lobectomy, nodulectomy, or isthmusectomy or equivalent partial thyroidectomy.

TN.8.138 Re-exploratory thyroid surgery (item 30297)

Item 30297 is for re-exploratory thyroid surgery where prior thyroid surgery and associated scar tissue increases the complexity of surgery. For completion hemithyroidectomy on the contralateral side to a previous hemithyroidectomy for thyroid cancer, item 30306 is the appropriate item.

TN.8.139 Personal performance of a Synacthen Stimulation Test (item 30097)

A 0900h serum cortisol (0830-0930) less than 100 nmol/L indicates adrenal deficiency and a Synacthen Test is not required.

A 0900h serum cortisol (0830-0930) greater than 400 nmol/L indicates adrenal sufficiency and a Synacthen Test is not required. An exception to this is when testing women on oral contraception where cortisol levels may be higher due to increases in cortisol-binding globulin and this threshold may not exclude women with adrenal insufficiency.

TN.8.140 Excision of graft material - Items 35581 and 35582

For items 35581 and 35582 the size of the excised graft material must be histologically tested and confirmed.

TN.8.141 Application of items 51011 to 51171 (Sub-group 17)

Spinal surgery items 51011 to 51171 cannot be performed in conjunction with any other item (outside of subgroup 17) in Group T8 of the MBS (surgical operation items 30001 to 50952), when that surgical item is related to spinal surgery. Items 50600 to 50644 - spine surgery for scoliosis and kyphosis in paediatric patients - are excepted from this rule when claimed in conjunction with items 51113 and 51114.

Meaning of Motion Segment

Motion segment is defined as including all anatomical structures (including traversing and exiting nerve roots) between and including the top of the pedicle above to the bottom of the pedicle below.

Combined Anterior and Posterior Surgery

Combined anterior/ posterior surgery items 51061, 51062, 51063, 51064, 51065 and 51066 cannot be claimed with any item between 51020 and 51045 (i.e. items for spinal instrumentation, posterior bone graft and/or anterior column fusion).

Interpretation of Spinal Fusion

Lumbar spinal fusion may not be claimed for chronic low back pain for which a diagnosis has not been made.

TN.8.142 Spinal Decompression - Items 51011 to 51015

Items 51011 to 51015 are for services which include discectomy, decompression of central spinal canal by laminectomy or partial corpectomy (vertebral spurs and osteophytes; less than 50% of the vertebral body), and decompression of the subfacetal recess, the exit foramen and far lateral (intertransverse) space.

For decompression procedures, only one item is selected from 51011 to 51015.

For posterolateral spinal fusion without instrumentation, if a decompression procedure is combined with the fusion, two items numbers can be selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers can be selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items can be selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers can be selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

If more than 50% of a vertebral body is resected (piecemeal vertebrectomy) an item from 51051 to 51059 can be selected in addition to an item from 51011 to 51015.

Items 51011 to 51015 can be used when the purpose of the laminectomy is exposure or posterior spinal release.

TN.8.143 Spinal Instrumentation (cervical, thoracic and lumbar) - Items 51020 to 51026

Items 51020 to 51026 are intended for spinal instrumentation at any level. The appropriate item is determined by the number of motion segments instrumented, barring item 51020 which applies to one vertebra.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

TN.8.144 Posterior and/or Posterolateral (intertransverse or facet joint) bone graft (cervical, thoracic and lumbar) - Items 51031 to 51036

Items 51031 to 51036 are for services which include local morcellized, artificial or harvested bone graft with or without bone morphogenic protein (BMP).

For posterolateral spinal fusion without instrumentation, if a decompression is combined with the fusion, two items numbers are selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumental spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

TN.8.145 Anterior column fusion, with or without implant, or limited vertebrectomy (less than 50%) and anterior fusion (cervical, thoracic and lumbar) - Items 51041 to 51045

Items 51041 to 51045 are for services which include placement of local morcellized, artificial, harvested bone graft, bone morphogenic protein (BMP) and prosthetic devices into the invertebral space. Artificial bone grafting materials must be used in accordance with the manufacturer's instructions.

Items 51041 to 51045 are to be selected irrespective of surgical approach (anterior, direct lateral or posterior via open or minimally invasive techniques).

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

For and instrumented anterior cervical decompression and fusion, (with or without cage) three items are selected: one from 51011 to 51015, one from 51020 to 51026, and one from 51041 to 51045.

Items 51041 to 51045 cannot be claimed with any item between 51051 and 51059 if performed at the same motion segment.

If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item from outside the spinal surgery schedule.

TN.8.146 Spinal Osteotomy and/or vertebrectomy - Items 51051 to 51059

Items 51051 to 51059 are intended for spinal osteotomy and/or vertebrectomy at any level.

For the purpose of items 51054, 51055 and 51056, the definition of piecemeal or subtotal excision is the removal of at least 50% of the vertebral body.

Items 51051 to 51059 cannot be claimed with any item between 51041 and 51045 if performed at the same motion segment.

TN.8.147 Anterior and Posterior (combined) Spinal fusion under one anaesthetic via separate incisions - Items 51061 to 51066

Only one of these items should be billed for any appropriate combined anterior and posterior surgeries which are completed under one anaesthetic. The appropriate item is determined by the number of motion segments to which grafting and fusion occur.

These items cannot be claimed with any item between 51020 to 51026, 51031 to 51036 and 51041 to 51045.

If a laminectomy is included, an item from 51011 to 51015 can also be used appropriate to the level of decompression.

If spinal osteotomy or vertebrectomy (>50%) is performed as part of the combined anterior/posterior approach, it is appropriate to claim one item between 51051 to 51056 in addition to an item between 51061 to 51066.

TN.8.148 Odontoid Screw fixation – Item 51103

This item is not for use when another item is claimed for the management of the odontoid fracture.

TN.8.149 Application of items 51160 and 51166

If the spine surgeon performs their own exposure to the thoracic or lumbar spine then 51160 or 51165 can be added to the claim for the overall surgery. If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item but not in combination with 51160 or 51165. If an exposure surgeon claims a number from any section of the MBS schedule, the spinal surgeon cannot claim 51160 or 51165.

TN.8.150 Correction of Developmental Breast Abnormality - (Items 45060 to 45062)

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

TN.8.151 Mohs surgery service caseload

Services under items 31000, 31001 and 31002 should make up at least 90% of a Mohs surgeon's caseload of items 31000-31005 annually.

TN.8.152 Colonoscopy Items (items 32222-32229)

Colonoscopy items (items 32222-32229)

It is expected that clinicians using the MBS items for colonoscopy also refer to national guidelines such as the National Health and Medical Research Council (NHMRC) Clinical Practice Guidelines for Surveillance Colonoscopy (NHMRC guidelines). For more information on clinical practice guidelines for surveillance colonoscopy see the colorectal cancer pages on the <u>Cancer Council Australia website</u>.

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

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

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

General practitioners should ensure colonoscopy referral practices align with applicable national guidelines, including the Royal Australian College of General Practitioners' guidelines for preventive activities in general practice (<u>the red book</u>). In addition, general practitioners are urged to recommend biennial FOBT screening to age-appropriate patients.

Colonoscopy where a polyp/polyps are removed

Items 32222-32226 and 32228 provide for diagnostic colonoscopy when claimed alone. Where a polyp or polyps are removed during the colonoscopy, item 32229 should also be claimed in association with the appropriate colonoscopy item.

Definition of previous history (items 32222-32225)

For items 32223-32225 the most appropriate item to be billed is determined by the previous history of the patient. The previous history for the purpose of these items is defined by number, size and type of adenomas removed during any previous colonoscopy.

Although with a patient with a previous history of 1-2 low risk adenomas (<10mm with no high-risk histological features) is eligible for a colonoscopy every five years under item 32223, clinical guidlines indicate that colonoscopy every 10 years is sufficient.

Definition of moderate risk of colorectal cancer due to family history (item 32223)

For item 32223 a patient is considered at moderate risk of colorectal cancer if there is moderate risk family history of colorectal cancer – defined as:

- 1 first degree relative less than 55 years of age at diagnosis; OR
- 2 first degree relatives with a history of colorectal cancer; OR
- 1 first degree relative and 2 second degree relatives with a history of colorectal cancer.

The national clinical practice guidelines support the use of FOBT as a first line test for patients with a low risk family history of colorectal cancer.

Exception item (item 32228)

Timing of colonoscopy following polypectomy should conform to the recommended surveillance intervals set out in clinical guidelines, taking into account individualised risk assessment. In the absence of reliable clinical history, clinicians should use their best clinical judgement to determine the interval between testing and the item that best suits the condition of the patient. Where the clinician is unable to access sufficient patient information to enable a colonoscopy to be performed under items 32222-32226, but in their opinion there is a clinical need for a colonoscopy, then item 32228 should be used. This item is available once per patient per lifetime.

Time intervals

Items 32223, 32224, 32225 and 32226 have time intervals for repeat colonoscopy which are consistent with guidelines. These services are payable under Medicare only when provided in accordance with the approved intervals.

Patients may fit several categories and the most appropriate fit is a matter for clinician judgement with the highest risk indicating what subsequent colonoscopy intervals are appropriate. The examples provided below show that the result of the histopathology will not lengthen the surveillance intervals (in the case of patient with familial adenomatous polyposis (FAP) or Lynch syndrome) and may actually shorten the surveillance intervals.

Example 1

A patient at high risk of colorectal cancer with FAP or Lynch syndrome has a number of polyps removed at a surveillance colonoscopy. Item 32226 and 32229 are the appropriate items to bill. If the histology result returns 1-2 adenomas for patients at low to moderate risk then the next surveillance colonoscopy is recommended in 5 years. However, the patient's familial condition means that a shorter interval (12 months) is recommended and payable.

Example 2

A patient at moderate risk of colorectal cancer because of family history has a number of polyps removed at a surveillance colonoscopy. Item 32223 and 32229 are the appropriate items to bill based on the patient's family history. If the histology testing returns showing an adenoma with high-risk histological features then the next surveillance colonoscopy is recommended in 3 years instead of 5 years.

How to use the items with new patients who have undergone previous colonoscopy

Patients whose care continues within one practice should have the relevant history readily available to guide decision making. For new patients, practitioners should make reasonable efforts to establish a patient's previous colonoscopy history. This includes seeking information from My Health Record, the records department of the hospital where the previous procedure occurred, the GP or the patient. The patients' MBS claims history for colonoscopy services will also assist with this.

For audit purposes it is important to record the most appropriate item. In accordance with good practice, clinicians are required to maintain records that include pathology results which must be made available to the patient or other practitioners as required.

The Australian Commission on Safety and Quality in Health Care's <u>Colonoscopy Clinical Care Standard</u> states all facilities and clinicians delivering colonoscopy services must provide a timely copy of the colonoscopy report and histology result to the patient and their GPs. Compliance with the Colonoscopy Clinical Care Standard is mandatory under the Australian Health Service Safety and Quality Accreditation Scheme.

Patient eligibility for colonoscopy services

The Department of Human Services (DHS) will be able to confirm whether a colonoscopy service has been claimed by an individual patient and the date of service. It will also be able to confirm any restriction on the frequency of the item claimed which would prevent a rebate from being paid if the service was provided again within the restricted period. Patients can seek clarification from the DHS by calling 132 011.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through <u>myGov</u> or the Express Plus Medicare mobile app.

Further information about these services can be found on the Department of Human Services website.

Practitioners providing colonoscopy services can call Medicare on **132 150** to check the patient's claiming history. The patient's Medicare card number will be required together with the range of item numbers to be checked. For example, the new item numbers for colonoscopy services are in the range 32222-32229. The operator will interrogate the patient's claiming history and provide advice on any claims paid for a colonoscopy service within the range of items specified and the date of the service.

Providers can also check a patient's eligibility via <u>Health Professional Online Services</u> (HPOS). HPOS will be able to return advice on whether a service is payable or not payable.

All patients who require a colonoscopy will be eligible for a service. However, MBS rebates will not be payable for services which do not meet the clinical indications and the item requirements for a colonoscopy or a repeat colonoscopy where the interval is specified in the item. Practitioners should ensure that their practice conforms to the approved clinical guidelines.

The DHS enquiry lines for providers and for patients is available 24 hours a day, seven days a week. Further information about these services can be found on the Department of Human Services website.

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

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

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

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

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

Assistance at Multiple Operations

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

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 25012 or 25015).
- For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).
- For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).
- For a perfusion service in association with *after hours emergency surgery (item 25050).

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

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

Definition of Emergency

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

Definition of After Hours

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

TN.10.4 Deriving the Schedule Fee under the RVG

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

ITEM	DESCRIPTION	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	0 Modifier - Physical sttaus		\$20.10
22012	2 Central Venous Pressure Monitoring		\$60.30
	TOTAL	34	\$683.40

After Hours Emergency Services

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

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

Definition of Radical Surgery for the RVG

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

Multiple Anaesthesia Services

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

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE
20790	Anaesthesia for open Cholecystectomy	8	\$160.80
20752	Incisional Hernia	6	(lower value than $20790 = 20752$ schedule fee not payable) \$120.60
23111	Time - 2hrs 30mins	11	\$221.10
25015	Physical Status - Over 75	1	\$20.10
	TOTAL	20	\$402.00

Prolonged Anaesthesia

Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

TN.10.5 Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation)

Medicare benefits for RVG services (including sedation) are only payable where both the staffing and the facility in which the service was rendered meets the following minimum guidelines. These guidelines are based on protocols established by the Australian and New Zealand College of Anaesthetists.

Staffing

- Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present to care exclusively for the patient;
- Where the patient is a young child, is elderly or has any serious medical condition (such as significant cardio-respiratory disease or danger of airway compromise), an anaesthetist should be present to administer sedation and monitor the patient;
- In all other cases, an appropriately trained medical practitioner, other than the proceduralist, is required to be in exclusive attendance on the patient during the procedure, to administer sedation and to monitor the patient; and
- There must be sufficient equipment (including oxygen, suction and appropriate medication), to enable resuscitation should it become necessary.

Facilities

The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

- An operating table, trolley or chair which can be readily tilted;
- Adequate uncluttered floor space to perform resuscitation, should this become necessary;
- Adequate suction and room lighting;
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient;
- A self inflating bag suitable for artificial ventilation together with a range of equipment for advance airway management;
- Appropriate drugs for cardiopulmonary resuscitation;
- A pulse oximeter; and
- Ready access to a defibrillator.

These requirements apply equally to dental anaesthesia or sedation services provided under items in Group T10, Subgroup 20 of the RVG.

TN.10.6 Account Requirements

Before a benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out in the General Explanatory Notes of the Medicare Benefits Schedule are required on the anaesthetist's account:

- **the anaesthetist's account** must show the name/s of the medical practitioner/s who performed the associated operation/s. In addition, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- **the assistant anaesthetist's account** must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.
- **the perfusionist's account** must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

TN.10.7 General Information

The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.8).

It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 26 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.9)

Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph TN.7.1. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

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

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

It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.

The administration of epidural anaesthesia during labour is covered by items 18216 or 18219 (18226 and 18227 for afer hours) in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

For the purposes of items 18216 and 18226, one attendance means that the medical practitioner cannot claim either of these items if the additional attendance is to optimise the initial treatment. Optimise means extension or improvement in analgesic quality of an existing block, without the insertion of a new block as a separate procedure.

TN.10.8 Additional Services Performed in Connection with Anaesthesia - Subgroup 19

Included in the RVG format are a number of additional or 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 25012, and/or item 25015, and/or items 25020, 25025 and/or when the basic surgical item value is 10 or more units, and/or is conjunction with items in group T10 Subgroup 13 (Shoulder and Axilla), or with items 23170 - 24136 (for procedures of greater than four hours duration) noting this is not an exhaustive list.

Item 22042

This item can be co-claimed with item 20142 (anaesthesia for lens surgery), when anaesthesia or sedation was also provided by the same anaesthetist.

Item 22042 cannot be co-claimed with item 20142, 20144, 20145 and 20147 when a general anaesthetic is the primary anaesthetic approach.

TN.10.9 Assistance in the Administration of Anaesthesia

The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

Therapeutic and Diagnostic services covered by Subgroup 19 items (such as blood transfusion, pressure monitoring, insertion of CVC, etc) are payable only once per patient per anaesthetic episode. Where these services are provided by the assistant anaesthetist these services are eligible for Medicare benefits only where the same service is not also claimed by the primary anaesthetist.

Assistance at anaesthesia in connection with emergency treatment (Item 25200)

Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death. Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.

Assistance in the administration of elective anaesthesia (Item 25205)

A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

For the purposes of Item 25205, a 'complex paediatric case' involves one or more of the following:

- the need for invasive monitoring (intravascular or transoesophageal); or
- organ transplantation; or
- craniofacial surgery; or
- major tumour resection; or
- separation of conjoint twins.

TN.10.10 Perfusion Services - (Items 22055 to 22075)

Perfusion services covered by items 22055-22075 have been included in the RVG format.

As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate, i.e.

(a) the basic units allocated to whole body perfusion under item 22060:

22060 WHOLE BODY PERFUSION, CARDIAC BYPASS, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) (See para TN.10.10 of explanatory notes to this Category)

(b) plus, the time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136), for example:

23170 4:01 HOURS TO 4:10 HOURS (21 basic units)

plus, where appropriate

(c) modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 - 25020), for example:

Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is not more than 3 years or at least 75 years (1 basic unit)

The time component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

Item 22065 may only be used in association with item 22060.

Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10.

The medical practitioner providing the service must comply with the training requirements in the Australian and New Zealand College of Anaesthetists *Guidelines for Major Extracorporeal Perfusion* (PS27).

Benefits are not payable if another person primarily and/or continuously operates the Heart Lung Machine.

TN.10.12 Discontinued Procedure - (Item 21990)

Item 21990 applies when a patient has been anaesthetised but the proposed procedure has been abandoned prior to surgery commencing.

Claims should include notation of the surgery or procedure which had been proposed.

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

TN.10.13 Anaesthesia in Connection with a Procedure not Identified as Attracting a Medicare Benefit for Anaesthesia - (Item 21997)

Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary.

TN.10.14 Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905)

Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

TN.10.15 Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172)

Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

TN.10.16 Anaesthesia in Connection with an Oral and Maxillofacial Service - (Category 4 of the Medicare Benefits Schedule)

Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG. Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

TN.10.17 Nerve or Plexus Blocks for Post Operative Pain - (Items 22031 to 22041) Items 22031 to 22041

Benefits are only payable for intra-operative nerve or plexus blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22041.

Items 22031 and 22036

For items 22031 and 22036, postoperative pain management means that the injected therapeutic substance is expected to prolong the analgesic effect of the epidural or intrathecal technique.

Item 22031 (initial intrathecal or epidural injection)

Benefits are payable under item 22031 for the initial intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, for the control of post-operative pain. Benefit is not payable for subsequent intra-operative intrathecal and epidural injection (item 22036) in the same anaesthetic episode. Where subsequent infusion is provided post operatively, to maintain analgesia, benefit would be payable under items 18222 or 18225.

Item 22036 (subsequent intrathecal or epidural injection)

Benefits are payable under item 22036 for subsequent intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, performed intra-operatively, for postoperative pain management, where the catheter is already in-situ. Benefits are not payable under this item where the initial injection was performed intra-operatively, under item 22031, in the same anaesthetic episode.

Item 22041 (plexus or nerve block)

Benefits are payable under item 22041 in addition to the general anaesthesia for the related procedure.

TN.10.18 Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192)

The term 'extensive' in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteocomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

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

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

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

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

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

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

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

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

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

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

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

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

Some examples of upper abdomen would be:

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

Some examples of lower abdomen would be:

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

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

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

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

Benefits are not payable under item 20911 for diagnostic ureteroscopy.

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

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

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

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

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

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

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

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

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

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

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

TR.8.1 Mechanical thrombectomy - (Item 35414)

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

(a) has a designated stroke unit;

(b) is equipped and has staff available or on call so that it is capable of providing the following to a patient on a 24-hour basis:

(i) the services of a specialist or consultant physician who has the training required under paragraph (b) of item 35414;

(ii) diagnostic imaging services using advanced imaging techniques, which must include computed tomography, computed tomography angiography, digital subtraction angiography, magnetic resonance imaging, and magnetic resonance angiography; and

(iii) care from a team of health practitioners which includes a stroke physician, a neurologist, a neurosurgeon, a radiologist, an anaesthetist, an intensive care unit specialist, a medical imaging technologist, and a nurse;

(c) has dedicated endovascular angiography facilities; and

(d) has written procedures for assessing and treating patients who have, or may have, experienced a stroke.

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

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

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

THERAPEUTIC PROCEDURES ITEMS

T1. MIS PROCE	CELLANEOUS THERAPEUTIC 1. HYPERBARIC OXYGEN THERAP DURES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 1. Hyperbaric Oxygen Therapy
	HYPERBARIC, OXYGEN THERAPY, for treatment of localised non-neurological soft tissue radiation injuries excluding radiation-induced soft tissue lymphoedema of the arm after treatment for breast cancer, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance.
13015	(See para TN.1.1 of explanatory notes to this Category) Fee: \$258.85 Benefit: 75% = \$194.15 85% = \$220.05
	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision o a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance
13020	(See para TN.1.1 of explanatory notes to this Category) Fee: 263.00 Benefit: $75\% = 197.25$ $85\% = 223.55$
	HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour)
13025	(See para TN.1.1 of explanatory notes to this Category) Fee: \$117.55 Benefit: 75% = \$88.20 85% = \$99.95
	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of a hour)
13030	(See para TN.1.1 of explanatory notes to this Category) Fee: \$166.05 Benefit: 75% = \$124.55 85% = \$141.15
T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 2. DIALYSI
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 2. Dialysis
	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day
13100	(See para TN.1.2 of explanatory notes to this Category)Fee: \$138.85Benefit: $75\% = 104.15 $85\% = 118.05
13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendances

	SCELLANEOUS THERAPEUTIC EDURES 2. DIA			
	time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day			
	(See para TN.1.2 of explanatory notes to this Category) Fee: \$72.35 Benefit: 75% = \$54.30 85% = \$61.50			
	Planning and management of home dialysis (either haemodialysis or peritoneal dialysis), by a comphysician in the practice of his or her specialty of renal medicine, for a patient with end-stage renardisease, and supervision of that patient on self-administered dialysis, to a maximum of 12 claims year	al		
13104	(See para TN.1.3, TN.1.23 of explanatory notes to this Category) Fee: \$150.30 Benefit: 85% = \$127.80			
	Haemodialysis for a patient with end-stage renal disease if:			
	(a) the service is provided by a registered nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner; and	d		
	(b) the service is supervised by the medical practitioner (either in person or remotely); and			
	(c) the patient's care is managed by a nephrologist; and			
	(d) the patient is treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely); and			
	(e) the patient is not an admitted patient of a hospital; and			
	(f) the service is provided in a Modified Monash 7 area			
13105	Fee: \$601.45 Benefit: 100% = \$601.45			
	DECLOTTING OF AN ARTERIOVENOUS SHUNT			
13106	Fee: \$123.30 Benefit: 75% = \$92.50 85% = \$104.85			
	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.)			
13109	Fee: \$231.40 Benefit: 75% = \$173.55 85% = \$196.70			
	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS, removal of (including catheter cuffs) (Anaes.)			
13110	Fee: \$232.15 Benefit: 75% = \$174.15 85% = \$197.35			
	SCELLANEOUS THERAPEUTIC EDURES 3. ASSISTED REPRODUCTIVE SER	VICE		
	Group T1. Miscellaneous Therapeutic Procedures			
	Subgroup 3. Assisted Reproductive Services			
	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 1	n, and		

13200 13206, 13218 applies - being services rendered during 1 treatment cycle - INITIAL cycle in a single

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES

3. ASSISTED REPRODUCTIVE SERVICES

	calendar year
	(See para TN.1.4 of explanatory notes to this Category) Fee: \$3,160.50 Benefit: 75% = \$2370.40 85% = \$3075.80 Extended Medicare Safety Net Cap: \$1,702.30
	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - each cycle SUBSEQUENT to the first in a single calendar year
13201	(See para TN.1.4 of explanatory notes to this Category) Fee: \$2,956.30 Benefit: 75% = \$2217.25 85% = \$2871.60 Extended Medicare Safety Net Cap: \$2,471.05
	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE THAT IS CANCELLED BEFORE OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, semen preparation, ultrasound examinations, but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which Item 13200, 13201, 13203, 13206, 13218, applies being services rendered during 1 treatment cycle
13202	(See para TN.1.4 of explanatory notes to this Category) Fee: \$473.00 Benefit: 75% = \$354.75 85% = \$402.05 Extended Medicare Safety Net Cap: \$66.00
	OVULATION MONITORING SERVICES, for artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which Item 13200, 13201, 13202, 13206, 13212, 13215, 13218, applies
13203	(See para TN.1.4 of explanatory notes to this Category) Fee: \$494.55 Benefit: 75% = \$370.95 85% = \$420.40 Extended Medicare Safety Net Cap: \$109.90
	ASSISTED REPRODUCTIVE TECHNOLOGIES TREATMENT CYCLE using either the natural cycle or oral medication only to induce oocyte growth and development, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies
13206	(See para TN.1.4 of explanatory notes to this Category)Fee: $$473.00$ Benefit: $75\% = 354.75 $85\% = 402.05 Extended Medicare Safety Net Cap: $$66.00$
	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle
13209	(See para TN.1.4 of explanatory notes to this Category) Fee: \$86.05 Benefit: 75% = \$64.55 85% = \$73.15 Extended Medicare Safety Net Cap: \$11.05

	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	(a) the attendance is by video conference; and
	(b) item 13209 applies to the attendance; and
	(c) the patient is not an admitted patient; and
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies
	(See para TN.1.21 of explanatory notes to this Category) Derived Fee: 50% of the fee for item 13209. Benefit: 85% of the derived fee Extended Medicare Safety Net Cap: \$5.40
	Oocyte retrieval for the purpose of assisted reproductive technologies-only if rendered in connection with a service to which item 13200, 13201 or 13206 applies (Anaes.)
13212	(See para TN.1.4 of explanatory notes to this Category) Fee: \$360.10 Benefit: 75% = \$270.10 85% = \$306.10 Extended Medicare Safety Net Cap: \$71.50
	Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination-only if rendered in connection with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.)
13215	(See para TN.1.4 of explanatory notes to this Category) Fee: \$112.90 Benefit: 75% = \$84.70 85% = \$96.00 Extended Medicare Safety Net Cap: \$49.50
	PREPARATION of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206, 13212 applies (Anaes.)
13218	(See para TN.1.4, TN.1.5 of explanatory notes to this Category)Fee: \$806.25Benefit: 75% = \$604.7085% = \$721.55Extended Medicare Safety Net Cap: \$713.90
	Preparation of semen for the purpose of artificial insemination-only if rendered in connection with a service to which item 13203 applies

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		
13251	(See para TN.1.5 of explanatory notes to this Category) Fee: \$424.65 Benefit: 75% = \$318.50 85% = \$361.00 Extended Medicare Safety Net Cap: \$109.90		
	Processing and cryopreservation of semen for fertility preservation treatment before or after completion of gonadotoxic treatment for malignant or non-malignant conditions, in a post-pubertal male in Tanner stages II-V, up to 60 years old, if the patient is referred by a specialist or consultant physician, initial cryopreservation of semen (not including storage) - one of a maximum of two semen collection cycles per patient in a lifetime.		
13260	(See para TN.1.22 of explanatory notes to this Category) Fee: \$421.65 Benefit: 75% = \$316.25 85% = \$358.45 Extended Medicare Safety Net Cap: \$274.10		
	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required		
13290	Fee: \$207.50 Benefit: 75% = \$155.65 85% = \$176.40		
	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.)		
13292	Fee: \$415.25 Benefit: 75% = \$311.45 85% = \$353.00		
	CELLANEOUS THERAPEUTIC		
PROCE	DURES 4. PAEDIATRIC & NEONATAL		
PROCE			
PROCE	DURES 4. PAEDIATRIC & NEONATAL		
PROCE	DURES 4. PAEDIATRIC & NEONATAL Group T1. Miscellaneous Therapeutic Procedures		
PROCE 13300	BURES 4. PAEDIATRIC & NEONATAL Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or		
	BURES 4. PAEDIATRIC & NEONATAL Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate		
	BURES 4. PAEDIATRIC & NEONATAL Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate Fee: \$57.85 Benefit: 75% = \$43.40 85% = \$49.20		
13300	BURES 4. PAEDIATRIC & NEONATAL Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate Fee: \$57.85 Benefit: 75% = \$43.40 85% = \$49.20 UMBILICAL ARTERY CATHETERISATION with or without infusion		
13300	BURES4. PAEDIATRIC & NEONATALGroup T1. Miscellaneous Therapeutic ProceduresSubgroup 4. Paediatric & NeonatalUMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonateFee: \$57.85Benefit: 75% = \$43.40Fee: \$57.85Benefit: 75% = \$43.40VMBILICAL ARTERY CATHETERISATION with or without infusionFee: \$85.75Benefit: 75% = \$64.3585% = \$72.90BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection		
13300	BURES4. PAEDIATRIC & NEONATALGroup T1. Miscellaneous Therapeutic ProceduresSubgroup 4. Paediatric & NeonatalUMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonateFee: \$57.85Benefit: 75% = \$43.40Fee: \$57.85Benefit: 75% = \$43.40UMBILICAL ARTERY CATHETERISATION with or without infusionFee: \$85.75Benefit: 75% = \$64.3585% = \$72.90BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor		
13300	EDURES4. PAEDIATRIC & NEONATALGroup T1. Miscellaneous Therapeutic ProceduresSubgroup 4. Paediatric & NeonatalUMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonateFee: \$57.85Benefit: 75% = \$43.40Fee: \$57.85Benefit: 75% = \$43.40VMBILICAL ARTERY CATHETERISATION with or without infusionFee: \$85.75Benefit: 75% = \$64.3585% = \$72.90BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donorFee: \$339.45Benefit: 75% = \$254.60BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already		

T1. MIS PROCE	CELLANEOUS T	HERAPEUTIC	4. PAEDIATRIC & NEONATAL
	Fee: \$28.90	Benefit: 75% = \$21.70	
			- by open exposure in a person under 12 years of age (Anaes.)
13318	(See para TN.1.6 Fee: \$231.10	of explanatory notes to this Ca Benefit: 75% = \$173.3.	
			n a neonate via peripheral vein (Anaes.)
13319	Fee: \$231.10	Benefit: 75% = \$173.3	5 85% = \$196.45
	CELLANEOUS T DURES	HERAPEUTIC	5. CARDIOVASCULAR
	Group T1. Misc	ellaneous Therapeutic Pr	ocedures
		Sub	bgroup 5. Cardiovascular
		N OF CARDIAC RHYTHM c surgery (Anaes.)	M by electrical stimulation (cardioversion), other than in the
13400	Fee: \$98.35	Benefit: 75% = \$73.80	85% = \$83.60
	CELLANEOUS T DURES	HERAPEUTIC	6. GASTROENTEROLOGY
	Group T1. Misc	ellaneous Therapeutic Pre	ocedures
		Sube	group 6. Gastroenterology
	GASTRO-OES	OPHAGEAL balloon intuba	ation, for control of bleeding from gastric oesophageal varices
13506	Fee: \$187.45	Benefit: 75% = \$140.6	0 85% = \$159.35
T1. MIS PROCE	CELLANEOUS T DURES	HERAPEUTIC	8. HAEMATOLOGY
	Group T1. Misc	ellaneous Therapeutic Pr	ocedures
		Su	ubgroup 8. Haematology
	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for th purpose of transplantation (Anaes.)		luding allogeneic) or AUTOLOGOUS bone marrow for the
13700	Fee: \$338.60	Benefit: 75% = \$253.9	5 85% = \$287.85
	TRANSFUSION	NOF BLOOD, including co	ollection from donor
13703	Fee: \$121.40	Benefit: 75% = \$91.05	85% = \$103.20
	TRANSFUSION	OF BLOOD or bone man	row already collected
13706	(See para TN.1.7 Fee: \$84.70	of explanatory notes to this Ca Benefit: 75% = \$63.55	
		OF BLOOD for autologous fusion in emergency situati	s transfusion or when homologous blood is required for ion
13709	(See para TN 1.8)	of explanatory notes to this Ca	ategory)

T1. MIS PROCE	CELLANEOUS T DURES	HERAPEUTIC	8. HAEMATOLOGY	
	Fee: \$49.25	Benefit: 75% = \$36.95		
	THERAPEUTIC utilising continu- viability studies, other parameters	C HAEMAPHERESIS for t bus or intermittent flow tec if performed; continuous r with continuous registered	the removal of plasma or cellular (or both) elements of blood, chniques; including morphological tests for cell counts and monitoring of vital signs, fluid balance, blood volume and d nurse attendance under the supervision of a consultant ith a service to which item 13755 applies -payable once per	
13750	Fee: \$138.85	Benefit: 75% = \$104.1	5 85% = \$118.05	
	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuou registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day			
13755	Fee: \$138.85	Benefit: 75% = \$104.1	5 85% = \$118.05	
	THERAPEUTIC porphyria cutane		management of haemochromatosis, polycythemia vera or	
13757	Fee: \$74.10	Benefit: 75% = \$55.60	85% = \$63.00	
	IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for:			
	. chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or			
	. Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or			
	. acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogeneic bone marrow transplant; or			
	. multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or			
	. small round cell sarcomas; or			
	. primitive neuroectodermal tumour; or			
	. germ cell tumours which have relapsed following, or are refractory to, chemotherapy;			
	. germ cell tumours which have had an incomplete response to first line therapy.			
	- performed under the supervision of a consultant physician - each day.			
13760	Fee: \$774.80	Benefit: 75% = \$581.1	0 85% = \$690.10	
T1. MIS PROCE	CELLANEOUS T DURES	HERAPEUTIC	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT	
	Group T1. Misc	ellaneous Therapeutic Pro	ocedures	
	Subgr	oup 9. Procedures Associa	ted With Intensive Care And Cardiopulmonary Support	
Amend Fee	Central vein cath	eterisation, including unde	er ultrasound guidance where clinically appropriate, by	

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES

9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT

13815	percutaneous or	open exposure other than a service to which item 13318 applies (Anaes.)	
	No separate ultra	asound item is payable with this item. (Anaes.)	
	(See para TN.1.6 c	of explanatory notes to this Category)	
	Fee: \$115.45	Benefit: 75% = \$86.60 85% = \$98.15	
		BALLOON CATHETER, insertion of, including pulmonary wedge pressure and easurement (Anaes.)	
13818	(See para TN.1.10 Fee: \$115.50	of explanatory notes to this Category) Benefit: 75% = \$86.65 85% = \$98.20	
		L PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid y a specialist or consultant physician - each day	
13830	Fee: \$76.55	Benefit: 75% = \$57.45 85% = \$65.10	
		lation, including under ultrasound guidance where clinically appropriate, for veno- lmonary extracorporeal life support	
New	No separate ultra	asound item is payable with this item	
13832	Fee: \$895.85	Benefit: 75% = \$671.90 85% = \$811.15	
	Veno-arterial ca	rdiopulmonary extracorporeal life support, management of—the first day	
New 13834	Fee: \$501.55	Benefit: 75% = \$376.20 85% = \$426.35	
	Veno-arterial ca	rdiopulmonary extracorporeal life support, management of—each day after the first	
New 13835	Fee: \$116.70	Benefit: 75% = \$87.55 85% = \$99.20	
	Veno-venous put	Imonary extracorporeal life support, management of—the first day	
New 13837	Fee: \$501.55	Benefit: 75% = \$376.20 85% = \$426.35	
	Veno-venous pu	Imonary extracorporeal life support, management of—each day after the first	
New 13838	Fee: \$116.70	Benefit: 75% = \$87.55 85% = \$99.20	
		NCTURE and collection of blood for diagnostic purposes	
13839	Fee: \$23.40	Benefit: 75% = \$17.55 85% = \$19.90	
	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for venous pulmonary extracorporeal life support No separate ultrasound item is payable with this item		
New 13840	Fee: \$600.20	Benefit: 75% = \$450.15 85% = \$515.50	
	Intra-arterial cannulation, including under ultrasound guidance where clinically appropriate, for the purpose of intra-arterial pressure monitoring or arterial blood sampling (or both)		
	No separate ultra	sound item is payable with this item	
Amend Fee 13842	(See para TN.1.10 Fee: \$95.05	of explanatory notes to this Category) Benefit: 75% = \$71.30 85% = \$80.80	

PROCE	CELLANEOUS THERAPEUTIC DURES	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT		
		n-management including associated consultations and monitoring ynamic assessment and management on several occasions on a		
Amend				
Fee	(See para TN.1.10 of explanatory notes to the Equation of the second sec			
13848		18.95 85% = \$134.85		
A		of, for a patient admitted to an intensive care unit for ications arising from implantation or management of the device -		
Amend 13851	Fee: \$501.55 Benefit: 75% = \$3	76.20 85% = \$426.35		
		of, for a patient admitted to an intensive care unit, including rom implantation or management of the device - each day after		
Amend 13854	Fee: \$116.70 Benefit: 75% = \$8	7.55 85% = \$99.20		
		NT OF AND INITIATION OF MECHANICAL VENTILATION etic for surgery), outside an Intensive Care Unit, for the purpose Intensive Care Unit		
13857	(See para TN.1.10 of explanatory notes to th Fee: \$148.75 Benefit: 75% = \$1	his Category) 11.60 85% = \$126.45		
T1. MISC PROCEI	CELLANEOUS THERAPEUTIC DURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT		
	Group T1. Miscellaneous Therapeutic	c Procedures		
	Subgroup 10. Managemen	nt And Procedures Undertaken In An Intensive Care Unit		
	(Note: See]	nt And Procedures Undertaken In An Intensive Care Unit		
	(Note: See p Category fo MANAGEMENT of a patient in an Inte immediately available and exclusively p	nt And Procedures Undertaken In An Intensive Care Unit para T1.8 of Explanatory Notes to this		
13870	(Note: See p Category fo MANAGEMENT of a patient in an Inte immediately available and exclusively p attendances, electrocardiographic moni	nt And Procedures Undertaken In An Intensive Care Unit para T1.8 of Explanatory Notes to this or definition of an Intensive Care Unit) ensive Care Unit by a specialist or consultant physician who is rostered for intensive care - including initial and subsequent toring, arterial sampling and bladder catheterisation -		
13870	(Note: See p Category for MANAGEMENT of a patient in an Inte immediately available and exclusively p attendances, electrocardiographic moni management on the first day (H) (See para TN.1.9, TN.1.11, TN.1.10 of expl Fee: \$367.90 Benefit: 75% = \$2 MANAGEMENT of a patient in an Inte immediately available and exclusively p	nt And Procedures Undertaken In An Intensive Care Unit para T1.8 of Explanatory Notes to this or definition of an Intensive Care Unit) ensive Care Unit by a specialist or consultant physician who is rostered for intensive care - including initial and subsequent toring, arterial sampling and bladder catheterisation -		
13870	(Note: See p Category for MANAGEMENT of a patient in an Inte immediately available and exclusively p attendances, electrocardiographic moni management on the first day (H) (See para TN.1.9, TN.1.11, TN.1.10 of expl Fee: \$367.90 Benefit: 75% = \$2 MANAGEMENT of a patient in an Inte immediately available and exclusively p electrocardiographic monitoring, arteria	And Procedures Undertaken In An Intensive Care Unit para T1.8 of Explanatory Notes to this or definition of an Intensive Care Unit) ensive Care Unit by a specialist or consultant physician who is rostered for intensive care - including initial and subsequent toring, arterial sampling and bladder catheterisation - lanatory notes to this Category) 75.95 ensive Care Unit by a specialist or consultant physician who is rostered for intensive care - including all attendances, al sampling and bladder catheterisation - management on each notes to this Category)		

	CELLANEOUS THE DURES		10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
	by a specialist or co	onsultant physician who i	by indwelling catheter in an intensive care unit and managed is immediately available and exclusively rostered for ressure on any calendar day (up to a maximum of 4
	(See para TN.1.9, TN Fee: \$78.15	I.1.11, TN.1.10 of explanato Benefit: 75% = \$58.65	ry notes to this Category)
	VENTILATION, in	n an Intensive Care Unit,	OF AND INITIATION OF MECHANICAL not in association with any anaesthetic service, by a pose of subsequent ventilatory support (H)
13881	(See para TN.1.9, TN Fee: \$148.75	I.1.11 of explanatory notes t Benefit: 75% = \$111.60	
	invasive means wh ventilatory support	ere the only alternative to	e Care Unit, management of, by invasive means, or by non- o non-invasive ventilatory support would be invasive tant physician who is immediately available and exclusively
13882	(See para TN.1.9, TN Fee: \$117.10	I.1.11 of explanatory notes t Benefit: 75% = \$87.85	o this Category)
	care unit, managen		VENO VENOUS HAEMOFILTRATION, in an intensive asultant physician who is immediately available and he first day (H)
13885	(See para TN.1.9, TN Fee: \$156.10	I.1.11 of explanatory notes t Benefit: 75% = \$117.10	
	care unit, managen	nent by a specialist or con	VENO VENOUS HAEMOFILTRATION, in an intensive asultant physician who is immediately available and each day subsequent to the first day (H)
13888	(See para TN.1.9, TN Fee: \$78.15	I.1.11 of explanatory notes to Benefit: 75% = \$58.65	o this Category)
		ls of Care is provided out information about Goals	tside of an intensive care unit. Refer to explanatory note s of Care attendance
	goals of care for a	gravely ill patient lacking	e care unit, for at least 60 minutes spent in preparation of current goals of care, by a specialist in the specialty of ity 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
New 13899	(See para TN.1.11 of Fee: \$272.15	explanatory notes to this Ca Benefit: 75% = \$204.15	
	CELLANEOUS THE DURES	RAPEUTIC	11. CHEMOTHERAPEUTIC PROCEDURES
	Group T1. Miscell	aneous Therapeutic Pro	ocedures
		Subgroup 11	. Chemotherapeutic Procedures
13915	CYTOTOXIC CHI	EMOTHERAPY. admini:	stration of, either by intravenous push technique (directly

	CELLANEOUS THERAPEUTIC DURES 11. CHEMOTHERAPEUTIC PROCEDURES
	into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day, not being a service associated with photodynamic therapy with verteporfin or for the administration of drugs used immediately prior to, or with microwave (UHF radiowave) cancer therapy alone
	(See para TN.1.12 of explanatory notes to this Category)Fee: $\$66.10$ Benefit: $75\% = \$49.60$ $85\% = \$56.20$
	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day
13918	Fee: \$99.50 Benefit: 75% = \$74.65 85% = \$84.60
	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment
13921	Fee: \$112.55 Benefit: 75% = \$84.45 85% = \$95.70
	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode
13924	Fee: \$66.30 Benefit: 75% = \$49.75 85% = \$56.40
	CYTOTOXIC CHEMOTHERAPY, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not more than 1 hours duration - payable once only on the same day
13927	Fee: \$85.75 Benefit: 75% = \$64.35 85% = \$72.90
	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day
13930	Fee: \$119.70 Benefit: 75% = \$89.80 85% = \$101.75
	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment
13933	Fee: \$132.80 Benefit: 75% = \$99.60 85% = \$112.90
	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode
13936	Fee: \$86.50 Benefit: 75% = \$64.90 85% = \$73.55
	IMPLANTED PUMP OR RESERVOIR, loading of, with a cytotoxic agent or agents, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies
13939	(See para TN.1.13 of explanatory notes to this Category) Fee: \$99.50 Benefit: 75% = \$74.65 85% = \$84.60
	AMBULATORY DRUG DELIVERY DEVICE, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies
13942	(See para TN.1.13 of explanatory notes to this Category) Fee: \$66.30 Benefit: 75% = \$49.75 85% = \$56.40
13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY,

	SCELLANEOUS THERAPEUTIC EDURES	11. CHEMOTHERAPEUTIC PROCEDURES
	accessing of	
	Fee: \$53.35 Benefit: 75% = \$40.05 85% =	- \$45.35
	CYTOTOXIC AGENT, instillation of, into a body	cavity
13948	Fee: \$66.30 Benefit: 75% = \$49.75 85% =	= \$56.40
	SCELLANEOUS THERAPEUTIC EDURES	12. DERMATOLOGY
	Group T1. Miscellaneous Therapeutic Procedure	es
	Subgroup	12. Dermatology
	UVA or UVB phototherapy administered in a whol associated consultations other than the initial consu specialist in the specialty of dermatology	le body cabinet or hand and foot cabinet including iltation, if treatment is initiated and supervised by a
	Applicable not more than 150 times in a 12 month	period
14050	(See para TN.1.14 of explanatory notes to this Category) Fee: \$53.60 Benefit: 75% = \$40.20 85% =	
	Laser photocoagulation using laser radiation in the neck, including any associated consultation, if:	treatment of vascular abnormalities of the head or
	(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 141 apply) in any 12 month period (Anaes.)	
14100	(See para TN.1.15 of explanatory notes to this Category) Fee: \$154.95 Benefit: 75% = \$116.25 85% Extended Medicare Safety Net Cap: \$124.00	
		Ota, other than melanocytic naevi (common moles), if any associated consultation, up to a maximum of 6 or any of items 14100 to 14118 apply) in any 12
14106	(See para TN.1.15 of explanatory notes to this Category) Fee: \$162.70 Benefit: 75% = \$122.05 85%	
14115	(See para TN.1.15 of explanatory notes to this Category) Fee: \$260.60 Benefit: 75% = \$195.45 85%	
14118	Laser photocoagulation using laser radiation in the	

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	CELLANEOUS THERAPEUTIC DURES 12. DERMATOLOGY
	haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period—area of treatment more than 300 cm ² (Anaes.)
	(See para TN.1.15 of explanatory notes to this Category) Fee: \$330.95 Benefit: 75% = \$248.25 85% = \$281.35
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, if:
	(a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 to 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and
	(b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.)
14124	(See para TN.1.15 of explanatory notes to this Category) Fee: \$154.95 Benefit: 75% = \$116.25 85% = \$131.75
	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDURES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 13. Other Therapeutic Procedures

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	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
	(See para TN.1.16 of explanatory notes to this Category)
	Fee: \$240.65 Benefit: 75% = \$180.50 85% = \$204.60
14201	Extended Medicare Safety Net Cap: \$36.10
	POLY-L-LACTIC ACID, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953
	(See para TN.1.16 of explanatory notes to this Category)
	Fee: \$121.80 Benefit: 75% = \$91.35 85% = \$103.55
14202	Extended Medicare Safety Net Cap: \$18.30
	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)
	(See para TN.1.4, TN.1.17 of explanatory notes to this Category)
14203	Fee: \$51.95 Benefit: 75% = \$39.00 85% = \$44.20
	HORMONE OR LIVING TISSUE IMPLANTATION by cannula
	(See para TN.1.4, TN.1.17 of explanatory notes to this Category)
14206	Fee: $\$36.15$ Benefit: $75\% = \$27.15$ $85\% = \$30.75$
	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent
14209	Fee: \$90.10 Benefit: 75% = \$67.60 85% = \$76.60

T1. MIS PROCE	CELLANEOUS THE DURES	RAPEUTIC	13. OTHER THERAPEUTIC PROCEDURES
	INTUSSUSCEPTI	ON, management of fluid	or gas reduction for (Anaes.)
14212	Fee: \$188.25	Benefit: 75% = \$141.20	85% = \$160.05
	infusion to the suba		NG OF reservoir, with a therapeutic agent or agents, for ce, with or without re-programming of a programmable table pain
14218	Fee: \$99.50	Benefit: 75% = \$74.65	85% = \$84.60
			R DELIVERY OF THERAPEUTIC AGENTS, accessing of, to which item 13945 applies
14221	Fee: \$53.35	Benefit: 75% = \$40.05	85% = \$45.35
			n or without the use of stimulus dosing techniques, including associated consultation (Anaes.)
14224	Fee: \$71.50	Benefit: 75% = \$53.65	85% = \$60.80
	subarachnoid or epi		NG of reservoir, with baclofen, for infusion to the out re-programming of a programmable pump, for the
14227	(See para TN.1.18 of Fee: \$99.50	explanatory notes to this Ca Benefit: 75% = \$74.65	
			R insertion or replacement of, for connection to a the management of severe chronic spasticity with baclofen
14230	(See para TN.1.18 of Fee: \$302.80	explanatory notes to this Ca Benefit: 75% = \$227.10	
	epidural catheter, an		ion or replacement of, and connection to intrathecal or ith baclofen, with or without programming of the pump, for (Anaes.) (Assist.)
14233	(See para TN.1.18 of Fee: \$367.70	explanatory notes to this Ca Benefit: 75% = \$275.80	
	insertion, and conne	ection of pump to cathete	on of, AND intrathecal or epidural SPINAL CATHETER r and loading of reservoir with baclofen, with or without ent of severe chronic spasticity (Anaes.) (Assist.)
14236	(See para TN.1.18 of Fee: \$670.50	explanatory notes to this Ca Benefit: 75% = \$502.90	
	intrathecal or epidu	ral SPINAL CATHETER	NFUSION PUMP, OR removal or repositioning of R, for the management of severe chronic spasticity (Anaes.)
14239	(See para TN.1.18 of Fee: \$161.95	explanatory notes to this Ca Benefit: 75% = \$121.50	
	SUBCUTANEOUS severe chronic spas		INAL CATHETER, insertion of, for the management of
14242	(See para TN.1.18 of Fee: \$481.25	explanatory notes to this Ca Benefit: 75% = \$360.95	itegory)
14245	IMMUNOMODUL	ATING AGENT, admin	istration of, by intravenous infusion for at least 2 hours

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES

13. OTHER THERAPEUTIC PROCEDURES

duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme

 (See para TN.1.19 of explanatory notes to this Category)

 Fee: \$99.50
 Benefit: 75% = \$74.65
 85% = \$84.60

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES

14. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN EMERGENCY DEPARTMENT

	Group T1. Miscellaneous Therapeutic Procedures	
	Subgroup 14. Management and Procedures Undertaken in an Emergency Department	
	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a specialist in the practice of the specialist's speciality 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.)	
New 14255	Fee: \$150.75 Benefit: 75% = \$113.10 85% = \$128.15	
	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 speciality 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.)	
New 14256	Fee: \$289.90 Benefit: 75% = \$217.45 85% = \$246.45	
	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.)	
New 14257	Fee: \$577.35 Benefit: 75% = \$433.05 85% = \$492.65	
	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 practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	
New 14258	Fee: \$113.10 Benefit: 75% = \$84.85 85% = \$96.15	
	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.)	
New 14259	Fee: \$217.45 Benefit: 75% = \$163.10 85% = \$184.85	
	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.)	
New 14260	Fee: \$433.00 Benefit: 75% = \$324.75 85% = \$368.05	
New 14263	Minor procedure on a patient by 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	

	CELLANEOUS T DURES	14. MANAGEMENT AND PROCEDURES HERAPEUTIC UNDERTAKEN IN AN EMERGENCY DEPARTMENT
	on the patient by 5019 (Anaes.)	the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or
	Fee: \$53.05	Benefit: 75% = \$39.80 85% = \$45.10
N	specialty of eme conjunction with	ot a minor procedure) on a patient by a specialist in the practice of the specialist's regency medicine at a recognised emergency department of a private hospital, in an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5, 5017 or 5019 (Anaes.)
New 14264	Fee: \$119.45	Benefit: 75% = \$89.60 85% = \$101.55
	specialist's spec hospital, in conj	on a patient by a medical practitioner (except a specialist in the practice of the alty of emergency medicine) at a recognised emergency department of a private unction with an attendance on the patient by the practitioner described in item 5021, 0, 5031, 5032, 5033, 5035 or 5036 (Anaes.)
New 14265	Fee: \$39.80	Benefit: 75% = \$29.85 85% = \$33.85
	practice of the sprivate hospital,	t a minor procedure) on a patient by a medical practitioner (except a specialist in the becialist's specialty of emergency medicine) at a recognised emergency department of a in conjunction with an attendance on the patient by the practitioner described in item 7, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)
New 14266	Fee: \$89.60	Benefit: 75% = \$67.20 85% = \$76.20
	(a) is provided b conjunction with 5013, 5014, 501	thout aftercare, of all fractures and dislocations suffered by a patient that: y a specialist in the practice of the specialist's specialty of emergency medicine in an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5, 5017 or 5019; and cognised emergency department of a private hospital (Anaes.)
New 14270	Fee: \$133.95	Benefit: 75% = \$100.50 85% = \$113.90
	(a) is provided b emergency medi item 5021, 5022	thout aftercare, of all fractures and dislocations suffered by a patient that: y a medical practitioner (except a specialist in the practice of the specialist's specialty of cine) in conjunction with an attendance on the patient by the practitioner described in 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and cognised emergency department of a private hospital (Anaes.)
New 14272	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
		nemical or physical restraint of a patient by a specialist in the practice of the specialist's gency medicine at a recognised emergency department of a private hospital
New 14277	Fee: \$150.75	Benefit: 75% = \$113.10 85% = \$128.15
	Application of c	nemical or physical restraint of a patient by a medical practitioner (except a specialist in e specialist's specialty of emergency medicine) at a recognised emergency department
New 14278	Fee: \$113.10	Benefit: 75% = \$84.85 85% = \$96.15
New 14280	Anaesthesia (wh (a) is managed b recognised emer (b) occurs in cor	ether general anaesthesia or not) of a patient that: y a specialist in the practice of the specialist's specialty of emergency medicine at a gency department of a private hospital; and junction with an attendance on the patient that is described in item 5001, 5004, 5011, 4, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and

	CELLANEOUS THERAPEUTIC	14. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN EMERGENCY DEPARTMENT
	(c) is not anaesthesia provided by a spe	cialist anaesthetist to which an item in Group T7 or T10 applies
	Fee: \$150.75 Benefit: 75% = \$1	13.10 85% = \$128.15
New	emergency medicine) at a recognised e (b) occurs in conjunction with an attend 5012, 5013, 5014, 5016, 5017, 5019, 50	sia or not) of a patient that: or (except a specialist in the practice of the specialist's specialty of mergency department of a private hospital; and lance on the patient that is described in item 5001, 5004, 5011, 021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and cialist anaesthetist to which an item in Group T7 or T10 applies
14283	Fee: \$113.10 Benefit: 75% = \$8	4.85 85% = \$96.15
New	recognised emergency department of a (b) occurs in conjunction with an attend 5012, 5013, 5014, 5016, 5017, 5019, 50	actice of the specialist's specialty of emergency medicine at a
14285	Fee: \$150.75 Benefit: 75% = \$1	13.10 85% = \$128.15
New 14288	emergency medicine) at a recognised e (b) occurs in conjunction with an attend 5012, 5013, 5014, 5016, 5017, 5019, 50 (c) is not anaesthesia provided by a spe	For except a specialist in the practice of the specialist's specialty of mergency department of a private hospital; and lance on the patient that is described in item 5001, 5004, 5011, 021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and cialist anaesthetist to which an item in Group T7 or T10 applies $4.85 85\% = \$96.15$
T2. RAI	DIATION ONCOLOGY	1. SUPERFICIAL
l	Group T2. Radiation Oncology	
	Group T2. Radiation Oncology	Subgroup 1. Superficial
		Subgroup 1. Superficial anaesthetic for radiotherapy are payable under Group T10)
	(Benefits for administration of general RADIOTHERAPY, SUPERFICIAL (in	-
15000	(Benefits for administration of general RADIOTHERAPY, SUPERFICIAL (in substances), not being a service to whic fractionated treatment is given - 1 field	anaesthetic for radiotherapy are payable under Group T10) ncluding treatment with xrays, radium rays or other radioactive
15000	(Benefits for administration of general RADIOTHERAPY, SUPERFICIAL (in substances), not being a service to which fractionated treatment is given - 1 field Fee: \$43.25 Benefit: 75% = \$3 Radiotherapy, superficial (including tree	anaesthetic for radiotherapy are payable under Group T10) neluding treatment with xrays, radium rays or other radioactive th another item in this Group applies each attendance at which 2.45 85% = \$36.80 ratment with x-rays, radium rays or other radioactive substances), m in this Group applies - each attendance at which fractionated

T2. RAD	DIATION ONCOLOGY	1. SUPERFICIAL
	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technic	que is applied
	- 1 field	
15006	Fee: \$95.85 Benefit: 75% = \$71.90 85% = \$81.50	
	Radiotherapy, superficial attendance at which a single dose technique is appl a maximum of 5 additional fields	ied - 2 or more fields up to
15009	Derived Fee: The fee for item 15006 plus for each field in excess of 1, an amount of	of \$18.85
	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is g	given to an eye
15012	Fee: \$54.30 Benefit: 75% = \$40.75 85% = \$46.20	
T2. RAD		2. ORTHOVOLTAGE
	Group T2. Radiation Oncology	
	Subgroup 2. Orthovoltage	
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which given at 3 or more treatments per week - 1 field	h fractionated treatment is
15100	(See para TN.2.1 of explanatory notes to this Category) Fee: \$48.45 Benefit: 75% = \$36.35 85% = \$41.20	
	Radiotherapy, deep or orthovoltage each attendance at which fractionated tre treatments per week - 2 or more fields up to a maximum of 5 additional field fields)	
15103	(See para TN.2.1 of explanatory notes to this Category) Derived Fee: The fee for item 15100 plus for each field in excess of 1, an amount of	of \$19.10
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at whic given at 2 treatments per week or less frequently	ch fractionated treatment is
	- 1 field	
15106	Fee: \$57.20 Benefit: 75% = \$42.90 85% = \$48.65	
	Radiotherapy, deep or orthovoltage each attendance at which fractionated tre treatments per week or less frequently - 2 or more fields up to a maximum of (rotational therapy being 3 fields)	
15109	Derived Fee: The fee for item 15106 plus for each field in excess of 1, an amount of	of \$23.05
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which sin	gle dose technique is

T2. RAI		GY	2. ORTHOVOLTAGE
	applied 1 field		
	Fee: \$122.15	Benefit: 75% = \$91.65 85% = \$	5103.85
		o or orthovoltage attendance at wh mum of 5 additional fields (rotatio	ich a single dose technique is applied - 2 or more onal therapy being 3 fields)
15115	Derived Fee: The	fee for item 15112 plus for each field	in excess of 1, an amount of \$48.05
T2. RAI		GY	3. MEGAVOLTAGE
	Group T2. Radiati	on Oncology	
		Subgroup 3	. Megavoltage
		COLOGY TREATMENT, using c h treatment is given	obalt unit or caesium teletherapy unit each
	- 1 field		
15211	Fee: \$55.60	Benefit: 75% = \$41.70 85% = \$	47.30
			esium teletherapy unit - each attendance at which of 5 additional fields (rotational therapy being 3
15214	Derived Fee: The	fee for item 15211 plus for each field	in excess of 1, an amount of \$32.40
		cilities - each attendance at which	single photon energy linear accelerator with or treatment is given - 1 field - treatment delivered to
15215	Fee: \$60.60	Benefit: 75% = \$45.45 85% = \$	51.55
		cilities - each attendance at which	single photon energy linear accelerator with or treatment is given - 1 field - treatment delivered to
15218	Fee: \$60.60	Benefit: 75% = \$45.45 85% = \$	51.55
		cilities - each attendance at which	single photon energy linear accelerator with or treatment is given - 1 field - treatment delivered to
15221	Fee: \$60.60	Benefit: 75% = \$45.45 85% = \$	51.55
	without electron fa	cilities - each attendance at which	single photon energy linear accelerator with or treatment is given - 1 field - treatment delivered to by items 15215, 15218 and 15221
15224	Fee: \$60.60	Benefit: 75% = \$45.45 85% = \$	51.55
			single photon energy linear accelerator with or treatment is given - 1 field - treatment delivered to
15227	•		

T2. RAI	DIATION ONCOLOGY		3. MEGAVOLTAGE
	Fee: \$60.60 Benefit: 75%	a = \$45.45 85% = \$51.55	
	RADIATION ONCOLOGY TREA without electron facilities - each at maximum of 5 additional fields (ro (lung)	ttendance at which treatment is giv	ven - 2 or more fields up to a
15230	Derived Fee: The fee for item 15215	5 plus for each field in excess of 1, an	amount of \$38.55
	RADIATION ONCOLOGY TREA without electron facilities - each at maximum of 5 additional fields (re (prostate)	ttendance at which treatment is giv	ven - 2 or more fields up to a
15233	Derived Fee: The fee for item 15218	8 plus for each field in excess of 1, an	amount of \$38.55
	RADIATION ONCOLOGY TREA without electron facilities - each at maximum of 5 additional fields (re (breast)	ttendance at which treatment is giv	ven - 2 or more fields up to a
15236	Derived Fee: The fee for item 15221	1 plus for each field in excess of 1, an	amount of \$38.55
	RADIATION ONCOLOGY TREA without electron facilities - each at maximum of 5 additional fields (re for diseases and conditions not cov	ttendance at which treatment is giv otational therapy being 3 fields) - t	ven - 2 or more fields up to a reatment delivered to primary site
15239	Derived Fee: The fee for item 15224	4 plus for each field in excess of 1, an	amount of \$38.55
	RADIATION ONCOLOGY TREA without electron facilities - each at maximum of 5 additional fields (re	ttendance at which treatment is giv	
15242	Derived Fee: The fee for item 15227	7 plus for each field in excess of 1, an	amount of \$38.55
	RADIATION ONCOLOGY TREA minimum higher energy of at least treatment is given - 1 field - treatm	t 10MV photons, with electron faci	ilities - each attendance at which
15245	Fee: \$60.60 Benefit: 75%	b = \$45.45 85% = \$51.55	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate)		
15248	Fee: \$60.60 Benefit: 75%	a = \$45.45 85% = \$51.55	
	RADIATION ONCOLOGY TREA minimum higher energy of at least treatment is given - 1 field - treatm	t 10MV photons, with electron faci	ilities - each attendance at which
15251	Fee: \$60.60 Benefit: 75%	a = \$45.45 85% = \$51.55	
	RADIATION ONCOLOGY TREA minimum higher energy of at least treatment is given - 1 field - treatm by items 15245, 15248 or 15251	t 10MV photons, with electron faci	
	ey nemis 152 15, 152 16 of 15251		

T2. RAD	DIATION ONCOLOGY 3. MEGAVOLTAGE
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site
15257	Fee: \$60.60 Benefit: 75% = \$45.45 85% = \$51.55
	RADIATION ORADIATION ONCOLOGY treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10mv photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung)
15260	Derived Fee: The fee for item 15245 plus for each field in excess of 1, an amount of \$38.55
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate)
15263	Derived Fee: The fee for item 15248 plus for each field in excess of 1, an amount of \$38.55
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast)
15266	Derived Fee: The fee for item 15251 plus for each field in excess of 1, an amount of \$38.55
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266
15269	Derived Fee: The fee for item 15254 plus for each field in excess of 1, an amount of \$38.55
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site
15272	Derived Fee: The fee for item 15257 plus for each field in excess of 1, an amount of \$38.55
	RADIATION ONCOLOGY TREATMENT with IGRT imaging facilities undertaken:
	(a) to implement an IMRT dosimetry plan prepared in accordance with item 15565; and
	(b) utilising an intensity modulated treatment delivery mode (delivered by a fixed or dynamic gantry linear accelerator or by a helical non C-arm based linear accelerator), once only at each attendance at which treatment is given.
15275	Fee: \$185.85 Benefit: 75% = \$139.40 85% = \$158.00
T2. RAD	DIATION ONCOLOGY 4. BRACHYTHERAPY
	Group T2. Radiation Oncology
	Subgroup 4. Brachytherapy
15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater

	DIATION ONCOLO	DGY 4. BRACHYTHERAP'	
	than 115 days us	ing manual afterloading techniques (Anaes.)	
	Fee: \$362.70	Benefit: 75% = \$272.05 85% = \$308.30	
		E TREATMENT ALONE using radioactive sealed sources having a half-life greater ing automatic afterloading techniques (Anaes.)	
15304	Fee: \$362.70	Benefit: 75% = \$272.05 85% = \$308.30	
		E TREATMENT ALONE using radioactive sealed sources having a half-life of less cluding iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)	
15307	Fee: \$687.65	Benefit: 75% = \$515.75 85% = \$602.95	
		E TREATMENT ALONE using radioactive sealed sources having a half-life of less cluding iodine, gold, iridium or tantalum using automatic afterloading techniques	
15308	Fee: \$687.65	Benefit: 75% = \$515.75 85% = \$602.95	
		L TREATMENT ALONE using radioactive sealed sources having a half-life greater ing manual afterloading techniques (Anaes.)	
15311	Fee: \$338.55	Benefit: 75% = \$253.95 85% = \$287.80	
		L TREATMENT ALONE using radioactive sealed sources having a half-life greater ing automatic afterloading techniques (Anaes.)	
15312	Fee: \$336.10	Benefit: 75% = \$252.10 85% = \$285.70	
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)		
15315	Fee: \$664.70	Benefit: 75% = \$498.55 85% = \$580.00	
		L TREATMENT ALONE using radioactive sealed sources having a half-life of less cluding iodine, gold, iridium or tantalum using automatic afterloading techniques	
15316	Fee: \$664.70	Benefit: 75% = \$498.55 85% = \$580.00	
		TRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed half-life greater than 115 days using manual afterloading techniques (Anaes.)	
15319	Fee: \$412.55	Benefit: 75% = \$309.45 85% = \$350.70	
	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)		
15320	Fee: \$412.55	Benefit: 75% = \$309.45 85% = \$350.70	
	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manua afterloading techniques (Anaes.)		
15323	Fee: \$733.55	Benefit: 75% = \$550.20 85% = \$648.85	
	sources having a	TRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed half-life of less than 115 days including iodine, gold, iridium or tantalum using ading techniques (Anaes.)	
	1		

T2. RA[DIATION ONCOLOGY	4. BRACHYTHERAPY
	IMPLANTATION OF A SEALED RADIOACTIVE SC including iodine, gold, iridium or tantalum) to a region, (intrathecal) nerve block, requiring surgical exposure and	under general anaesthesia, or epidural or spinal
15327	Fee: \$798.00 Benefit: 75% = \$598.50 85% = \$71	3.30
	IMPLANTATION OF A SEALED RADIOACTIVE SC including iodine, gold, iridium or tantalum) to a region, (intrathecal) nerve block, requiring surgical exposure and (Anaes.)	under general anaesthesia, or epidural or spinal
15328	Fee: \$798.00 Benefit: 75% = \$598.50 85% = \$71	3.30
	IMPLANTATION OF A SEALED RADIOACTIVE SC including iodine, gold, iridium or tantalum) to a site (inc subcutaneous sites), where the volume treated involves r exposure and using manual afterloading techniques (Ana	luding the tongue, mouth, salivary gland, axilla, nultiple planes but does not require surgical
15331	Fee: \$757.75 Benefit: 75% = \$568.35 85% = \$67	3.05
	IMPLANTATION OF A SEALED RADIOACTIVE SC including iodine, gold, iridium or tantalum) to a site (inc subcutaneous sites), where the volume treated involves r exposure and using automatic afterloading techniques (A	luding the tongue, mouth, salivary gland, axilla, nultiple planes but does not require surgical
15332	Fee: \$757.75 Benefit: 75% = \$568.35 85% = \$67	3.05
	IMPLANTATION OF A SEALED RADIOACTIVE SC including iodine, gold, iridium or tantalum) to a site whe plane but does not require surgical exposure and using n	ere the volume treated involves only a single
15335	Fee: \$687.65 Benefit: 75% = \$515.75 85% = \$60	2.95
	IMPLANTATION OF A SEALED RADIOACTIVE SC including iodine, gold, iridium or tantalum) to a site whe plane but does not require surgical exposure and using a	ere the volume treated involves only a single
15336	Fee: \$687.65 Benefit: 75% = \$515.75 85% = \$60	2.95
	PROSTATE, radioactive seed implantation of, radiation ultrasound guidance, for localised prostatic malignancy a tumour not palpable or visible by imaging) or T2 (tumou score of less than or equal to 7 and a prostate specific an the time of diagnosis. The procedure must be performed urologist.	at clinical stages T1 (clinically inapparent ir confined within prostate), with a Gleason tigen (PSA) of less than or equal to 10ng/ml at
15338	(See para TN.2.2 of explanatory notes to this Category) Fee: \$950.55 Benefit: 75% = \$712.95 85% = \$86	5.85
	REMOVAL OF A SEALED RADIOACTIVE SOURCE spinal nerve block (Anaes.)	E under general anaesthesia, or under epidural or
15339	Fee: \$77.40 Benefit: 75% = \$58.05 85% = \$65.8	30
	CONSTRUCTION AND APPLICATION OF A RADIO having a half-life of greater than 115 days, to treat intrac	
15342	Fee: \$193.35 Benefit: 75% = \$145.05 85% = \$16	4.35
	CONSTRUCTION AND APPLICATION OF A RADIO	

1 4. 1\74	DIATION ONCOL	.OGY	4. BRACHYTHERAPY
	intraoral or intra	anasal sites	
	Fee: \$515.90	Benefit: 75% = \$386.95 85% = \$438.5	55
	SUBSEQUENT 15345 each atte	CAPPLICATIONS OF RADIOACTIVE Mendance	OULD referred to in item 15342 or
15348	Fee: \$59.35	Benefit: 75% = \$44.55 85% = \$50.45	
		ON WITH OR WITHOUT INITIAL APPL . diameter to an external surface	JCATION OF RADIOACTIVE MOULD not
15351	Fee: \$118.45	Benefit: 75% = \$88.85 85% = \$100.70)
	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface		
15354	Fee: \$143.75	Benefit: 75% = \$107.85 85% = \$122.2	20
	radioactive mou	T APPLICATIONS OF RADIOACTIVE N and constructed for application to an externa of h is the first attendance to apply the mould	
15357	Fee: \$40.70	Benefit: 75% = \$30.55 85% = \$34.60	
T2. RAI	DIATION ONCOL	.OGY	5. COMPUTERISED PLANNING
	Group T2. Radi	iation Oncology	
		Subgroup 5. Computeri	ised Planning
		RADIOTHERAPY PL	ANNING
	single area for tr		entric xray or megavoltage machine or CT of a ed fields (not being a service associated with a
15500	(See para TN.2.3 o Fee: \$246.55	of explanatory notes to this Category) Benefit: 75% = \$184.95 85% = \$209.6	50
	single area, when		entric xray or megavoltage machine or CT of a for treatment by multiple fields, or of 2 areas a 15512 applies)
15503	(See para TN.2.3 o Fee: \$316.55	of explanatory notes to this Category) Benefit: 75% = \$237.45 85% = \$269.1	10
	or more areas, or	or of total body or half body irradiation, or o	entric xray or megavoltage machine or CT of 3 of mantle therapy or inverted Y fields, or of
		ed with a service to which item 15515 appl	is fields or several joined fields (not being a
15506	service associate		is fields or several joined fields (not being a ies)
15506	service associate (See para TN.2.3 o Fee: \$472.75 RADIATION F	ed with a service to which item 15515 apple of explanatory notes to this Category) Benefit: 75% = \$354.60 85% = \$401.8	is fields or several joined fields (not being a ies) 35 nit of a single area for treatment by a single

T2. RAD	DIATION ONCOLOGY 5. COMPUTERISED PLANNING
	Fee: \$213.65 Benefit: 75% = \$160.25 85% = \$181.65
	RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies)
15512	(See para TN.2.3 of explanatory notes to this Category) Fee: \$275.45 Benefit: 75% = \$206.60 85% = \$234.15
	RADIATION SOURCE LOCALISATION using a simulator or x-ray machine or CT of a single area, where views in more than 1 plane are required, for brachytherapy treatment planning for I125 seed implantation of localised prostate cancer, in association with item 15338
15513	(See para TN.2.3 of explanatory notes to this Category) Fee: \$311.45 Benefit: 75% = \$233.60 85% = \$264.75
	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies)
15515	(See para TN.2.3 of explanatory notes to this Category) Fee: \$398.80 Benefit: 75% = \$299.10 85% = \$339.00
	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks
15518	(See para TN.2.3 of explanatory notes to this Category) Fee: \$78.25 Benefit: 75% = \$58.70 85% = \$66.55
	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used
15521	(See para TN.2.3 of explanatory notes to this Category) Fee: \$345.35 Benefit: 75% = \$259.05 85% = \$293.55
	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields
15524	(See para TN.2.3 of explanatory notes to this Category) Fee: \$647.55 Benefit: 75% = \$485.70 85% = \$562.85
	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks
15527	(See para TN.2.3 of explanatory notes to this Category)Fee: $\$80.20$ Benefit: $75\% = \$60.15$ $85\% = \$68.20$
	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used
15530	(See para TN.2.3 of explanatory notes to this Category) Fee: \$357.80 Benefit: 75% = \$268.35 85% = \$304.15
15533	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields

T2. RAD	DIATION ONCOLOGY 5. COMPUTERISED PLANNING
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$678.40 Benefit: 75% = \$508.80 85% = \$593.70
	BRACHYTHERAPY PLANNING, computerised radiation dosimetry
15536	(See para TN.2.3 of explanatory notes to this Category) Fee: \$271.15 Benefit: 75% = \$203.40 85% = \$230.50
	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338
15539	(See para TN.2.3 of explanatory notes to this Category) Fee: \$637.35 Benefit: 75% = \$478.05 85% = \$552.65
	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
15550	(See para TN.2.3 of explanatory notes to this Category) Fee: \$669.15 Benefit: 75% = \$501.90 85% = \$584.45
	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY pre and post intravenous contrast medium, where:
	(a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and
	(b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and
	(c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and
	(d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images
15553	(See para TN.2.3 of explanatory notes to this Category) Fee: \$721.90 Benefit: 75% = \$541.45 85% = \$637.20
	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

T2. RAD	IATION ONCOLOGY 5. COMPUTERISED PLANNING
	3. a high-quality CT-image volume dataset is acquired for the relevant region of interest to be planned and treated; and
	4. the image set is suitable for the generation of quality digitally-reconstructed radiographic images.
	(See para TN.2.3 of explanatory notes to this Category)Fee: $\$721.90$ Benefit: $75\% = \$541.45$ $85\% = \$637.20$
	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 1 COMPLEXITY where:
	(a) dosimetry for a single phase three dimensional conformal treatment plan using CT image volume dataset and having a single treatment target volume and organ at risk; and
	(b) one gross tumour volume or clinical target volume, plus one planning target volume plus at least one relevant organ at risk as defined in the prescription must be rendered as volumes; and
	(c) the organ at risk must be nominated as a planning dose goal or constraint and the prescription must specify the organ at risk dose goal or constraint; and
	(d) dose volume histograms must be generated, approved and recorded with the plan; and
	(e) a CT image volume dataset must be used for the relevant region to be planned and treated; and
	(f) the CT images must be suitable for the generation of quality digitally reconstructed radiographic images
15556	(See para TN.2.3 of explanatory notes to this Category) Fee: \$675.05 Benefit: 75% = \$506.30 85% = \$590.35
	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 2 COMPLEXITY where:
	(a) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, two planning target volumes and one organ at risk defined in the prescription; or
	(b) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and two organ at risk dose goals or constraints defined in the prescription; or
	(c) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 1 complexity.
	All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images
15559	(See para TN.2.3 of explanatory notes to this Category) Fee: $\$880.40$ Benefit: $75\% = \$660.30$ $\$5\% = \795.70
15562	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3

T2. RADI	IATION ONCOLOGY	5. COMPUTERISED PLANNING
	COMPLEXITY - where:	
	(a) dosimetry for a three or more phase three dimensional co- volume dataset(s) with at least one gross tumour volume, three risk defined in the prescription; or	
	(b) dosimetry for a two phase three dimensional conformal t datasets with at least one gross tumour volume, and	reatment plan using CT image volume
	(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 to datasets with at least one gross tumour volume, one planning to goals or constraints defined in the prescription;	
	or	
	(d) image fusion with a secondary image (CT, MRI or PET) organ at risk volumes in conjunction with and as specified in c radiotherapy of level 2 complexity.	
	All gross tumour targets, clinical targets, planning targets and prescription must be rendered as volumes. The organ at risk m or constraints and the prescription must specify the organs at r volume histograms must be generated, approved and recorded must be used for the relevant region to be planned and treated, generation of quality digitally reconstructed radiographic image	ust be nominated as planning dose goals isk as dose goals or constraints. Dose with the plan. A CT image volume dataset . The CT images must be suitable for the
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$1,138.70 Benefit: 75% = \$854.05 85% = \$1054.00	
	Preparation of an IMRT DOSIMETRY PLAN, which uses on	e or more CT image volume datasets, if:
	(a) in preparing the IMRT dosimetry plan:	
	(i) the differential between target dose and normal tissue of assessment by a radiation oncologist; and	lose is maximised, based on a review and
	(ii) all gross tumour targets, clinical targets, planning targ volumes as defined in the prescription; and	ets and organs at risk are rendered as
	(iii) organs at risk are nominated as planning dose goals o the organs at risk as dose goals or constraints; and	r constraints and the prescription specifies
	 (iv) dose calculations and dose volume histograms are get using a specialised calculation algorithm, with prescription the plan; and 	
	(v) a CT image volume dataset is used for the relevant reg	ion to be planned and treated; and
15565	(vi) the CT images are suitable for the generation of quali	ty digitally reconstructed radiographic

T2. RAI	DIATION ONCOLOGY 5. COMPUTERISED PLANNING
	images; and
	(b) the final IMRT dosimetry plan is validated by the radiation therapist and the medical physicist, using robust quality assurance processes that include:
	(i) determination of the accuracy of the dose fluence delivered by the multi-leaf collimator and gantryposition (static or dynamic); and
	(ii) ensuring that the plan is deliverable, data transfer is acceptable and validation checks are completed on a linear accelerator; and
	(iii) validating the accuracy of the derived IMRT dosimetry plan; and
	(c) the final IMRT dosimetry plan is approved by the radiation oncologist prior to delivery.
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$3,366.85 Benefit: 75% = \$2525.15 85% = \$3282.15
T2. RAI	DIATION ONCOLOGY 6. STEREOTACTIC RADIOSURGERY
	Group T2. Radiation Oncology
	Subgroup 6. Stereotactic Radiosurgery
	STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning,
	simulation, dosimetry and treatment
15600	Fee: \$1,729.55 Benefit: 75% = \$1297.20 85% = \$1644.85
	Fee: \$1,729.55 Benefit: 75% = \$1297.20 85% = \$1644.85 7. RADIATION ONCOLOGY TREATMENT
	Fee: \$1,729.55 Benefit: 75% = \$1297.20 85% = \$1644.85 7. RADIATION ONCOLOGY VERIFICATION VERIFICATION
	Fee: \$1,729.55 Benefit: 75% = \$1297.20 85% = \$1644.85 T. RADIATION ONCOLOGY TRADIATION ONCOLOGY TRADIATION ONCOLOGY Group T2. Radiation Oncology Group T2. Radiation Oncology Group T2. Radiation Oncology
	Fee: \$1,729.55 Benefit: 75% = \$1297.20 85% = \$1644.85 7. RADIATION ONCOLOGY TREATMENT VERIFICATION Group T2. Radiation Oncology Subgroup 7. Radiation Oncology Treatment Verification RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item 15705
T2. RAI	Fee: \$1,729.55 Benefit: 75% = \$1297.20 85% = \$1644.85 RADIATION ONCOLOGY TREATMENT VERIFICATION Group 72. Radiation Oncology Subgroup 7. Radiation Oncology Treatment Verification RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category)
T2. RAI	Fee: \$1,729.55 Benefit: 75% = \$1297.20 85% = \$1644.85 7. RADIATION ONCOLOGY TREATMENT VERIFICATION ONCOLOGY Subgroup 7. Radiation Oncology Treatment Verification RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category) Fee: \$46.70 Benefit: 75% = \$35.05 85% = \$39.70 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
T2. RAI	Fee: \$1,729.55 Benefit: 75% = \$1297.20 85% = \$1644.85 CRADIATION ONCOLOGY TREATMENT VERIFICATION Group T2. Radiation Oncology Subgroup 7. Radiation Oncology Treatment Verification RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category) Fee: \$46.70 Benefit: 75% = \$35.05 85% = \$39.70 RADIATION ONCOLOGY TREATMENT VERIFICATION - multiple projection acquisition when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710 - each attendance at which treatment involving three or more fields is verified (ie maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category)
T2. RAI	Fee: \$1,729.55 Benefit: 75% = \$1297.20 85% = \$1644.85 INTRONONCOLOGY CRADIATION ONCOLOGY TREATMENT VERIFICATION ONCOLOGY TREATMENT VERIFICATION Group T2. Radiation Oncology Group T2. Radiation Oncology RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category) Fee: \$46.70 Benefit: 75% = \$35.05 85% = \$39.70 RADIATION ONCOLOGY TREATMENT VERIFICATION - multiple projection acquisition when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710 - each attendance at which treatment involving three or more fields is verified (ie maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category) Fee: \$77.85 Benefit: 75% = \$58.40 85% = \$66.20 (See para TN.2.4 of explanatory notes to this Category) Fee: \$77.85 Benefit: 75% = \$58.40 85% = \$66.20 RADIATION ONCOLOGY TREATMENT VERIFICATION - volumetric acquisition, when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15705 - each attendance

7. RADIATION ONCOLOGY TREATMENT VERIFICATION

	E #== ~~		
	Fee: \$77.85	Benefit: 75% = \$58.40 85	
	involving the use		ERIFICATION of planar or volumetric IGRT for IMRT, ws or projections or 1 volumetric image set to facilitate a at field positioning, if:
	(a) the treatment	technique is classified as IMR	T; and
			get volume or planning target volume) are tailored or e of healthy or normal tissues; and
	immediately price		re based on action algorithms and are given effect ery by qualified and trained staff considering complex odelling programs; and
			uires accuracy levels of less than 5mm (curative cases) e dose delivery to the target; and
	(e) the image dec	cisions and actions are docume	ented in the patient's record; and
	frequency of ima	iging, tolerance and action leve	pervising the process, including specifying the type and els to be incorporated in the process, reviewing the trend uring the treatment course and specifying action protoco
	(g) when treatmer required; and	ent adjustments are inadequate	to satisfy treatment protocol requirements, replanning is
		nfrastructure (hardware and so se, enabling both on line and o	oftware) is linked to the treatment unit and networked to ff line reviews.
5715	(See para TN.2.4 c Fee: \$77.85	of explanatory notes to this Categorian Benefit: 75% = \$58.40 85	
[2. RA[DGY	8. BRACHYTHERAPY PLANNING AN VERIFICATIO
	Group T2. Radia	ation Oncology	
		Subgroup 8. Brachy	therapy Planning And Verification
	BRACHYTHER	APY TREATMENT VERIFI	CATION - maximum of one only for each attendance.
.5800	(See para TN.2.4 c Fee: \$97.85	of explanatory notes to this Categorian Benefit: 75% = \$73.40 85	
	single area, when		ng a simulator, x-ray machine, CT or ultrasound of a e are required, for brachytherapy treatment planning, no
5850	Fee: \$202.70	Benefit: 75% = \$152.05	35% = \$172.30
			10. TARGETED INTRAOPERATIV

Group T2. Radiation Oncology

T2. RAI	10. TARGETED INTRAOPERATIVE DIATION ONCOLOGY RADIOTHERAPY
	Subgroup 10. Targeted Intraoperative Radiotherapy
	INTRAOPERATIVE RADIOTHERAPY
	BREAST, MALIGNANT TUMOUR, targeted intraoperative radiotherapy, using an Intrabeam® device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who:
	a) is 45 years of age or more; and
	b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and
	c) has an histologic Grade 1 or 2 tumour; and
	d) has an oestrogen-receptor positive tumour; and
	e) has a node negative malignancy; and
	f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and
	g) has no contra-indications to breast irradiation
15900	Fee: \$254.00 Benefit: 75% = \$190.50
T3. THE	ERAPEUTIC NUCLEAR MEDICINE
	Group T3. Therapeutic Nuclear Medicine
	INTRACAVITY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.)
16003	(See para TN.3.1 of explanatory notes to this Category) Fee: \$660.90 Benefit: 75% = \$495.70 85% = \$576.20
	Denerit. $7570 = 9475.70 = 0570 = 9570.20$
	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique Fee: \$507.85 Benefit: 75% = \$380.90 85% = \$431.70 ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose
	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique Fee: \$507.85 Benefit: 75% = \$380.90 85% = \$431.70 ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique
	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique Fee: \$507.85 Benefit: 75% = \$380.90 85% = \$431.70 ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique Fee: \$346.60 Benefit: 75% = \$259.95 85% = \$294.65
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique Fee: \$507.85 Benefit: 75% = \$380.90 85% = \$431.70 ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique Fee: \$346.60 Benefit: 75% = \$259.95 85% = \$294.65 INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose techniqueFee: \$507.85Benefit: 75% = \$380.9085% = \$431.70ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose techniqueFee: \$346.60Benefit: 75% = \$259.95Fee: \$346.60Benefit: 75% = \$259.9585% = \$294.65INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32Fee: \$299.85Benefit: 75% = \$224.9085% = \$254.90ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique Fee: \$507.85 Benefit: 75% = \$380.90 85% = \$431.70 ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique Fee: \$346.60 Benefit: 75% = \$259.95 85% = \$294.65 INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32 Fee: \$299.85 Benefit: 75% = \$224.90 85% = \$254.90 ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either:

T3. THE	ERAPEUTIC NUCLEAR MEDICINE	
	ADMINISTRATION OF ¹⁵³ SM-LEXIDRONAM for the relief of bone pain due to skeletal metastase (as indicated by a positive bone scan) where hormonal therapy and/or chemotherapy have failed and either the disease is poorly controlled by conventional radiotherapy or conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain.	
16018	Fee: \$2,481.55 Benefit: 75% = \$1861.20 85% = \$2396.85	
T4. OB	STETRICS	
	Group T4. Obstetrics	
	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if:	
	(a) the attendance is by video conference; and	
	(b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and	
	(c) the patient is not an admitted patient; and	
	(d) the patient:	
	(i) is located both:	
	(A) within a telehealth eligible area; and	
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or	
	(ii) is a care recipient in a residential care service; or	
	(iii) is a patient of:	
	(A) an Aboriginal Medical Service; or	
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies	
16399	(See para TN.4.12 of explanatory notes to this Category) Derived Fee: 50% of the fee for item 16401,16404,16406,16500,16590 or 16591. Benefit: 85% of the derived fee Extended Medicare Safety Net Cap: \$24.50	
	ANTENATAL CARE Antenatal service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitionerif: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; (b) the service is provided at, or from, a practice location in a regional, rural or remote area; (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day); (d) the service is not provided for an admitted patient of a hospital; and to a maximum of 10 service per pregnancy	
1 < 400	(See para TN.4.1 of explanatory notes to this Category) Fee: \$27.70 Benefit: 85% = \$23.55	
16400	Extended Medicare Safety Net Cap: \$11.25	
	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each attendance, other than a second or subsequent attendance in a single course of treatment	
16401	(See para TN.4.2 of explanatory notes to this Category) Fee: \$86.90 Benefit: 75% = \$65.20 85% = \$73.90 Extended Medicare Safety Net Cap: \$55.80	

T4. OB	STETRICS	
	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance SUBSEQUENT to the first attendance in a single course of treatment.	
16404	(See para AN.0.70, TN.4.2 of explanatory notes to this Category) Fee: \$43.70 Benefit: 75% = \$32.80 85% = \$37.15 Extended Medicare Safety Net Cap: \$33.50	
	Antenatal professional attendance, by an obstetrician or general practitioner, as part of a single course of treatment when the patient is referred by a participating midwife. Payable only once for a pregnancy	
16406	Fee: \$136.10 Benefit: 75% = \$102.10 85% = \$115.70 Extended Medicare Safety Net Cap: \$109.90	
	Postnatal professional attendance (other than a service to which any other item applies) if the attendance:	
	(a) is by an obstetrician or general practitioner; and	
	(b) is in hospital or at consulting rooms; and	
	(c) is between 4 and 8 weeks after the birth; and	
	(d) lasts at least 20 minutes; and	
	(e) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and	
	(f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided Payable once only for a pregnancy	
16407	(See para TN.4.13 of explanatory notes to this Category) Fee: \$72.85 Benefit: 75% = \$54.65 85% = \$61.95 Extended Medicare Safety Net Cap: \$47.40	
	Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance:	
	(a) is by:	
	(i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or	
	(ii) an obstetrician; or	
	(iii) a general practitioner; and	
	(b) is between 1 week and 4 weeks after the birth; and	
	(c) lasts at least 20 minutes; and	
	(d) is for a patient who was privately admitted for the birth; and	
	(e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided	
	Payable once only for a pregnancy	
16408	Fee: \$54.25 Benefit: 85% = \$46.15 Extended Medicare Safety Net Cap: \$35.30	

T4. OBS	STETRICS
	ANTENATAL ATTENDANCE
16500	(See para TN.4.3 of explanatory notes to this Category)Fee: \$47.90Benefit: 75% = \$35.9585% = \$40.75Extended Medicare Safety Net Cap: \$33.50
	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy (See para TN.4.3, TN.4.4 of explanatory notes to this Category)
16501	Fee: $\$142.80$ Benefit: $75\% = \$107.10$ $85\% = \$121.40$ Extended Medicare Safety Net Cap: $\$66.95$
	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day
16502	(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.90 Benefit: 75% = \$35.95 85% = \$40.75 Extended Medicare Safety Net Cap: \$22.35
	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance
16505	(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.90 Benefit: 75% = \$35.95 85% = \$40.75 Extended Medicare Safety Net Cap: \$22.35
	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, to a maximum of one visit per day
16508	(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.90 Benefit: 75% = \$35.95 85% = \$40.75 Extended Medicare Safety Net Cap: \$22.35
	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of - each professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance
16509	(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.90 Benefit: 75% = \$35.95 85% = \$40.75 Extended Medicare Safety Net Cap: \$22.35
	CERVIX, purse string ligation of (Anaes.)
16511	(See para TN.4.3 of explanatory notes to this Category)Fee: $$223.45$ Benefit: $75\% = 167.60 $85\% = 189.95 Extended Medicare Safety Net Cap: $$111.50$
	CERVIX, removal of purse string ligature of (Anaes.)
	(See para TN.4.3 of explanatory notes to this Category)Fee: $$64.50$ Benefit: $75\% = 48.40 $85\% = 54.85
16512	Extended Medicare Safety Net Cap: \$33.50
16514	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the

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	course of the confinement)
	(See para TN.4.3 of explanatory notes to this Category) Fee: \$37.25 Benefit: 75% = \$27.95 85% = \$31.70 Extended Medicare Safety Net Cap: \$16.80
	Management of vaginal birth as an independent procedure, if the patient's care has been transferred by another medical practitioner for management of the birth and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the birth (Anaes.)
16515	(See para TN.4.5, TN.4.10 of explanatory notes to this Category) Fee: \$640.95 Benefit: 75% = \$480.75 85% = \$556.25 Extended Medicare Safety Net Cap: \$178.40
	Management of labour, incomplete, if the patient's care has been transferred to another medical practitioner for completion of the birth (Anaes.)
16518	(See para TN.4.5, TN.4.10 of explanatory notes to this Category) Fee: \$457.85 Benefit: 75% = \$343.40 85% = \$389.20 Extended Medicare Safety Net Cap: \$178.40
	Management of labour and birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)
16519	(See para TN.4.5, TN.4.6, TN.4.10 of explanatory notes to this Category) Fee: \$705.05 Benefit: 75% = \$528.80 85% = \$620.35 Extended Medicare Safety Net Cap: \$334.40
	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)
16520	(See para TN.4.6, TN.4.10 of explanatory notes to this Category) Fee: \$640.95 Benefit: 75% = \$480.75 85% = \$556.25 Extended Medicare Safety Net Cap: \$334.40
	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;
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	(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);
	(i) acute fetal compromise evidenced by:
	(i) scalp pH less than 7.15; or
	(ii) scalp lactate greater than 4.0;
	(j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities:
	(i) prolonged bradycardia (less than 100 bpm for more than 2 minutes);
	(ii) absent baseline variability (less than 3 bpm);
	(iii) sinusoidal pattern;
	(iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability;
	(v) late decelerations;
	(k) pregnancy induced hypertension of at least 140/90 mm Hg associated with:
	(i) at least 2+ proteinuria on urinalysis; or
	(ii) protein-creatinine ratio greater than 30 mg/mmol; or
	(iii) platelet count less than 150×10^9 /L; or
	(iv) uric acid greater than 0.36 mmol/L;
	(l) 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

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	of myocardial dysfunction);
	(iii) previous renal or liver transplant;
	(iv) renal dialysis;
	(v) chronic liver disease with documented oesophageal varices;
	(vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L);
	(vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy;
	(viii) maternal height of less than 148 cm;
	(ix) a body mass index greater than or equal to 40;
	(x) pre-existing diabetes mellitus on medication prior to pregnancy;
	(xi) thyrotoxicosis requiring medication;
	(xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium;
	(xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation;
	(xiv) HIV, hepatitis B or hepatitis C carrier status positive;
	(xv) red cell or platelet iso-immunisation;
	(xvi) cancer with metastatic disease;
	(xvii) illicit drug misuse during pregnancy (Anaes.)
	(See para TN.4.7 of explanatory notes to this Category) Fee: \$1,655.40 Benefit: 75% = \$1241.55
	Management of vaginal birth, if the patient's care has been transferred by a participating midwife for management of the birth, including all attendances related to the birth. Payable once only for a pregnancy.
	(Anaes.)
16527	(See para TN.4.8 of explanatory notes to this Category) Fee: \$640.95 Benefit: 75% = \$480.75 85% = \$556.25 Extended Medicare Safety Net Cap: \$178.40
	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.)
16528	(See para TN.4.8 of explanatory notes to this Category) Fee: \$640.95 Benefit: 75% = \$480.75 85% = \$556.25 Extended Medicare Safety Net Cap: \$334.40
10020	Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.)
16530	(See para TN.4.5 of explanatory notes to this Category)Fee: \$390.50Benefit: 75% = \$292.9085% = \$331.95Extended Medicare Safety Net Cap: \$253.85

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	Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.)
16531	(See para TN.4.5, TN.4.14 of explanatory notes to this Category) Fee: \$781.00 Benefit: 75% = \$585.75
	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy
16533	(See para TN.4.3, TN.4.14 of explanatory notes to this Category) Fee: \$107.25 Benefit: 75% = \$80.45
	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy
16534	(See para TN.4.3, TN.4.14 of explanatory notes to this Category) Fee: \$107.25 Benefit: 75% = \$80.45
	POST-PARTUM CARE EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)
16564	(See para TN.4.10 of explanatory notes to this Category) Fee: \$221.50 Benefit: 75% = \$166.15 85% = \$188.30 Extended Medicare Safety Net Cap: \$222.95
	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.)
16567	(See para TN.4.10 of explanatory notes to this Category)Fee: $$323.90$ Benefit: $75\% = 242.95 $85\% = 275.35 Extended Medicare Safety Net Cap: $$222.95$
	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.)
16570	(See para TN.4.10 of explanatory notes to this Category) Fee: \$422.70 Benefit: 75% = \$317.05 85% = \$359.30 Extended Medicare Safety Net Cap: \$222.95
	CERVIX, repair of extensive laceration or lacerations (Anaes.)
16571	(See para TN.4.10 of explanatory notes to this Category) Fee: \$323.90 Benefit: 75% = \$242.95 Extended Medicare Safety Net Cap: \$222.95
	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)
16573	(See para TN.4.10 of explanatory notes to this Category)Fee: $$263.95$ Benefit: $75\% = 198.00 $85\% = 224.40 Extended Medicare Safety Net Cap: $$222.95$
	Planning and management, by a practitioner, of a pregnancy if:
16590	(a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and

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	(b) the patient intends to be privately admitted for the birth; and
	(c) the pregnancy has progressed beyond 28 weeks gestation; and
	(d) the practitioner has maternity privileges at a hospital or birth centre; and
	(e) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and
	(f) a service to which item 16591 applies is not provided in relation to the same pregnancy
	Payable once only for a pregnancy
	(See para TN.4.13, TN.4.9 of explanatory notes to this Category) Fee: \$378.70 Benefit: 75% = \$284.05 85% = \$321.90 Extended Medicare Safety Net Cap: \$222.95
	Planning and management, by a practitioner, of a pregnancy if:
	(a) the pregnancy has progressed beyond 28 weeks gestation; and
	(b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and
	(c) a service to which item 16590 applies is not provided in relation to the same pregnancy
	Payable once only for a pregnancy
16591	(See para TN.4.13, TN.4.9 of explanatory notes to this Category) Fee: \$144.95 Benefit: 75% = \$108.75 85% = \$123.25 Extended Medicare Safety Net Cap: \$111.50
	INTERVENTIONAL TECHNIQUES
	AMNIOCENTESIS, diagnostic
16600	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$64.50 Benefit: 75% = \$48.40 85% = \$54.85 Extended Medicare Safety Net Cap: \$33.50
	CHORIONIC VILLUS SAMPLING, by any route
16603	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$123.80 Benefit: 75% = \$92.85 85% = \$105.25 Extended Medicare Safety Net Cap: \$66.95
	Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)
	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$247.15 Benefit: 75% = \$185.40 85% = \$210.10
16606	Extended Medicare Safety Net Cap: \$133.85
16609	FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including

T4. OBS	STETRICS
	neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.)
	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$503.95 Benefit: 75% = \$378.00 85% = \$428.40 Extended Medicare Safety Net Cap: \$256.45
	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.)
16612	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$396.50 Benefit: 75% = \$297.40 85% = \$337.05
	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.)
16615	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$211.20 Benefit: 75% = \$158.40 85% = \$179.55
	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated
16618	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$211.20 Benefit: 75% = \$158.40 85% = \$179.55 Extended Medicare Safety Net Cap: \$105.95
	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios
16621	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$211.20 Benefit: 75% = \$158.40 85% = \$179.55
	FOETAL FLUID FILLED CAVITY, drainage of
16624	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$303.90 Benefit: 75% = \$227.95 85% = \$258.35 Extended Medicare Safety Net Cap: \$144.95
	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis
16627	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$618.70 Benefit: 75% = \$464.05 85% = \$534.00 Extended Medicare Safety Net Cap: \$312.15
T6. AN/	ESTHETICS 1. ANAESTHESIA CONSULTATION
Group T6. Anaesthetics	
	Subgroup 1. Anaesthesia Consultations
	Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if:
	(a) the attendance is by video conference; and
	(b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and
17609	(c) the patient is not an admitted patient; and

T6. ANA	ESTHETICS 1. ANAESTHESIA CONSULTATIONS
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service;
	for which a direction made under subsection 19 (2) of the Act applies
	(See para TN.6.4 of explanatory notes to this Category) Derived Fee: 50% of the fee for item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655. Benefit: 85% of the derived fee
	Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or \$500.00, whichever is the lesser amount
	ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION
	 (Professional attendance by a medical practitioner in the practice of ANAESTHESIA) a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system)
	- AND of not more than 15 minutes s duration, not being a service associated with a service to which items 2801 - 3000 apply
17610	(See para TN.6.1 of explanatory notes to this Category) Fee: \$44.35 Benefit: 75% = \$33.30 85% = \$37.70 Extended Medicare Safety Net Cap: \$133.05
	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 selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 15 minutes but not more than 30 minutes duration, not being a service associated with a service to which items 2801 - 3000 applies
17615	(See para TN.6.1 of explanatory notes to this Category) Fee: \$88.25 Benefit: 75% = \$66.20 85% = \$75.05 Extended Medicare Safety Net Cap: \$264.75
17620	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

T6. ANA	ESTHETICS	1. ANAESTHESIA CONSULTATIONS
	U	patient notes - and of more than 30 minutes but not more than ice associated with a service to which items 2801 - 3000 apply
	(See para TN.6.1 of explanatory notes to this C Fee: \$122.20 Benefit: 75% = \$91.6 Extended Medicare Safety Net Cap: \$3	5 85% = \$103.90
	patient undergoing advanced surgery exhaustive history and comprehensiv written patient management plan foll the patient, involving medical planni	titioner in the practice of anaesthesia for a consultation on a or who has complex medical problems involving an re examination of multiple systems, the formulation of a owing discussion with relevant health care professionals and/or ng of high complexity documented in the patient notes - and of eing a service associated with a service to which items 2801 -
17625	(See para TN.6.1 of explanatory notes to this C Fee: \$155.60 Benefit: 75% = \$116 Extended Medicare Safety Net Cap: \$4	70 85% = \$132.30
		O CONSULTATION (other than prior to anaesthesia)
	(Professional attendance by a specialist ar is referred to him or her)	naesthetist in the practice of ANAESTHESIA where the patient
	- a BRIEF consultation involving a shor	t history and limited examination
	- AND of not more than 15 minutes dur items 2801 - 3000 apply	ation, not being a service associated with a service to which
17640	(See para TN.6.2 of explanatory notes to this C Fee: \$44.35 Benefit: 75% = \$33.3 Extended Medicare Safety Net Cap: \$1	85% = \$37.70
	- a consultation involving a selective his of a written patient management plar	story and examination of multiple systems and the formulation
	- AND of more than 15 minutes but not with a service to which items 2801 -	<i>more than 30 minutes duration</i> , not being a service associated 3000 apply.
17645	(See para TN.6.2 of explanatory notes to this C Fee: \$88.25 Benefit: 75% = \$66.2 Extended Medicare Safety Net Cap: \$2	85% = \$75.05
		ory and comprehensive examination of multiple systems and
17650	- AND of more than 30 minutes but not	more than 45 minutes duration, not being a service associated

T6. ANAESTHETICS		1. ANAESTHESIA CONSULTATIONS
	with a service to which items 2801 - 3000 app	bly
	(See para TN.6.2 of explanatory notes to this Category) Fee: \$122.20 Benefit: 75% = \$91.65 85% = Extended Medicare Safety Net Cap: \$366.60	= \$103.90
		and comprehensive examination of multiple systems ent plan following discussion with relevant health care planning of high complexity,
	- AND of more than 45 minutes duration, not bei 2801 - 3000 apply.	ng a service associated with a service to which items
17655	(See para TN.6.2 of explanatory notes to this Category) Fee: \$155.60 Benefit: 75% = \$116.70 85% Extended Medicare Safety Net Cap: \$466.80	= \$132.30
		DNSULTATION, OTHER
	(Professional attendance by an anaesthetist in the p	practice of ANAESTHESIA)
		on of a major regional blockade in a patient in labour, curred, not being a service associated with a service to
17680	(See para TN.6.3 of explanatory notes to this Category) Fee: \$88.25 Benefit: 75% = \$66.20 85% = Extended Medicare Safety Net Cap: \$264.75	= \$75.05
		by an item in the range 17615-17625 is performed in-
	(a) the service is provided to a patient prior to an a and	dmitted patient episode of care involving anaesthesia;
	(b) the service is not provided to an admitted patie	ent of a hospital; and
	(c) the service is not provided on the day of admiss involving anaesthesia services; and	sion to hospital for the subsequent episode of care
	(d) the service is of more than 15 minutes duration	
17690		

T6. ANAESTHETICS 1. ANAESTHESIA CONSULTATIO	
	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: \$40.80 Benefit: 75% = \$30.60 85% = \$34.70 Extended Medicare Safety Net Cap: \$122.40
T7. RE0	GIONAL OR FIELD NERVE BLOCKS
	Group T7. Regional Or Field Nerve Blocks
	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion
18213	Fee: \$90.05 Benefit: 75% = \$67.55 85% = \$76.55
	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner
	Applicable once per presentation, per medical practitioner, per complete new procedure (Anaes.)
18216	(See para TN.10.7 of explanatory notes to this Category) Fee: \$192.95 Benefit: 75% = \$144.75 85% = \$164.05
	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by the medical practitioner extends beyond the first hour (Anaes.)
18219	Derived Fee: The fee for item 18216 plus \$19.30 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.
	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less
18222	(See para TN.7.2, TN.10.7 of explanatory notes to this Category) Fee: \$38.25 Benefit: 75% = \$28.70 85% = \$32.55
	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes
18225	(See para TN.7.2, TN.10.7 of explanatory notes to this Category) Fee: \$50.85 Benefit: 75% = \$38.15 85% = \$43.25
	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.
	Applicable once per presentation, per medical practitioner, per complete new procedure
18226	(See para TN.7.4, TN.10.7 of explanatory notes to this Category) Fee: \$289.35 Benefit: 75% = \$217.05 85% = \$245.95
	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.
18227	(See para TN.7.4, TN.10.7 of explanatory notes to this Category)

	Derived Fee: The fee for item 18226 plus \$29.05 for each additional 15 minutes or part there of beyond the first
	hour of attendance by the medical practitioner.
	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance
18228	Fee: \$63.50 Benefit: 75% = \$47.65 85% = \$54.00
	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.)
18230	Fee: \$242.25 Benefit: 75% = \$181.70 85% = \$205.95
	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.)
18232	(See para TN.7.3 of explanatory notes to this Category)Fee: $\$192.95$ Benefit: $75\% = \$144.75$ $85\% = \$164.05$
	EPIDURAL INJECTION of blood for blood patch (Anaes.)
18233	Fee: \$192.95 Benefit: 75% = \$144.75 85% = \$164.05
	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.)
18234	(See para TN.7.5 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85
	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.)
18236	(See para TN.7.5 of explanatory notes to this Category)Fee: $$63.50$ Benefit: $75\% = 47.65 $85\% = 54.00
	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies
18238	(See para TN.7.5 of explanatory notes to this Category) Fee: \$38.25 Benefit: 75% = \$28.70 85% = \$32.55
	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent
18240	(See para TN.7.5 of explanatory notes to this Category) Fee: \$95.10 Benefit: 75% = \$71.35 85% = \$80.85
	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.)
18242	(See para TN.7.5 of explanatory notes to this Category)Fee: $$38.25$ Benefit: $75\% = 28.70 $85\% = 32.55
	VAGUS NERVE, injection of an anaesthetic agent
18244	(See para TN.7.5 of explanatory notes to this Category) Fee: 102.40 Benefit: $75\% = 76.80 $85\% = 87.05
	PHRENIC NERVE, injection of an anaesthetic agent
18248	(See para TN.7.5 of explanatory notes to this Category) Fee: 90.05 Benefit: $75\% = 67.55 $85\% = 76.55
	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent
18250	(See para TN.7.5 of explanatory notes to this Category) Fee: $$63.50$ Benefit: $75\% = 47.65 $85\% = 54.00
	CERVICAL PLEXUS, injection of an anaesthetic agent
18252	(See para TN.7.5 of explanatory notes to this Category)

T7. REG	GIONAL OR FIELD NERVE BLOCKS	
	Fee: \$102.40 Benefit: 75% = \$76.80 85% = \$87.05	
	BRACHIAL PLEXUS, injection of an anaesthetic agent	
18254	(See para TN.7.5 of explanatory notes to this Category) Fee: \$102.40 Benefit: 75% = \$76.80 85% = \$87.05	
	SUPRASCAPULAR NERVE, injection of an anaesthetic agent	
18256	(See para TN.7.5 of explanatory notes to this Category) Fee: \$63.50 Benefit: 75% = \$47.65 85% = \$54.00	
	INTERCOSTAL NERVE (single), injection of an anaesthetic agent	
18258	(See para TN.7.5 of explanatory notes to this Category)Fee: $$63.50$ Benefit: $75\% = 47.65 $85\% = 54.00	
	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent	
18260	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$90.05$ Benefit: $75\% = \$67.55$ $85\% = \$76.55$	
	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.)	
18262	(See para TN.7.5 of explanatory notes to this Category) Benefit: $75\% = 47.65 $85\% = 54.00	
	PUDENDAL NERVE and or dorsal nerve, injection of anaesthetic agent	
18264	(See para TN.7.5 of explanatory notes to this Category) Fee: 102.40 Benefit: $75\% = 76.80 $85\% = 87.05	
	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block	
18266	(See para TN.7.5 of explanatory notes to this Category) Fee: \$63.50 Benefit: 75% = \$47.65 85% = \$54.00	
	OBTURATOR NERVE, injection of an anaesthetic agent	
18268	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$90.05$ Benefit: $75\% = \$67.55$ $85\% = \$76.55$	
	FEMORAL NERVE, injection of an anaesthetic agent	
18270	(See para TN.7.5 of explanatory notes to this Category) Fee: \$90.05 Benefit: 75% = \$67.55 85% = \$76.55	
	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent	
18272	(See para TN.7.5 of explanatory notes to this Category) Fee: \$63.50 Benefit: 75% = \$47.65 85% = \$54.00	
_	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level)	
18274	(See para TN.7.5 of explanatory notes to this Category) Benefit: $75\% = \$67.55$ 85\% = \$76.55	
	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)	
18276	(See para TN.7.5 of explanatory notes to this Category)	

	GIONAL OR FIELD NERVE BLOCKS	
	Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85	
	SCIATIC NERVE, injection of an anaesthetic agent	
	(See para TN.7.5 of explanatory notes to this Category)	
18278	Fee: \$90.05 Benefit: 75% = \$67.55 85% = \$76.55	
	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.)	
	(See para TN.7.5 of explanatory notes to this Category)	
18280	Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85	
	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure	
	(See para TN.7.5 of explanatory notes to this Category)	
18282	Fee: \$102.40 Benefit: 75% = \$76.80 85% = \$87.05	
	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.)	
	(See para TN.7.5 of explanatory notes to this Category)	
18284	Fee: \$150.00 Benefit: 75% = \$112.50 85% = \$127.50	
	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.)	
	block) (Allacs.)	
10000	(See para TN.7.5 of explanatory notes to this Category)	
18286	Fee: \$150.00Benefit: 75% = \$112.5085% = \$127.50COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.)	
	COELIAC FLEXUS OK SFLANCHNIC NEKVES, injection of an anaesthetic agent (Anaes.)	
10000	(See para TN.7.5 of explanatory notes to this Category)	
18288	Fee: \$150.00 Benefit: 75% = \$112.50 85% = \$127.50 CDANIAL NEDVE OTHER THAN TRICEMINAL destruction by a neurolatic count act being a	
	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.)	
10000		
18290	Fee: \$253.75 Benefit: 75% = \$190.35 85% = \$215.70	
	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to	
	which item 18354 applies (Anaes.)	
	(See para TN.7.5 of explanatory notes to this Category)	
18292	Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85	
	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.)	
18294	Fee: \$178.80 Benefit: 75% = \$134.10 85% = \$152.00	
	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	
18296	Fee: \$152.95 Benefit: 75% = \$114.75 85% = \$130.05	
	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner	
18297	Fee: \$60.30 Benefit: 75% = \$45.25 85% = \$51.30	
	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	
18298	Fee: \$178.80 Benefit: 75% = \$134.10 85% = \$152.00	

18. 501		1. GENERAL
	Group T8. Surgical Operations	
Subgroup 1. General		
	OPERATIVE PROCEDURE, not being a service to which any other item in this service to which an item in this Group would have applied had the procedure no medical grounds	
30001	(See para TN.8.5 of explanatory notes to this Category) Derived Fee: 50% of the fee which would have applied had the procedure not been dis	continued
	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at performed, including any associated consultation	which the procedure is
30003	Fee: \$36.90 Benefit: 75% = \$27.70 85% = \$31.40	
	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) which the procedure is performed, including any associated consultation	each attendance at
30006	Fee: \$47.25 Benefit: 75% = \$35.45 85% = \$40.20	
	LOCALISED BURNS, dressing of, under general anaesthesia (not involving gra	afting) (Anaes.)
30010	Fee: \$75.10 Benefit: 75% = \$56.35	
	EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving gra	afting) (Anaes.)
30014	Fee: \$157.90 Benefit: 75% = \$118.45	
	BURNS, excision of, under general anaesthesia, involving not more than 10 per where grafting is not carried out during the same operation (Anaes.) (Assist.)	cent of body surface,
30017	Fee: \$331.25 Benefit: 75% = \$248.45 85% = \$281.60	
	BURNS, excision of, under general anaesthesia, involving more than 10 per cen grafting is not carried out during the same operation (Anaes.) (Assist.)	t of body surface, where
30020	Fee: \$645.15 Benefit: 75% = \$483.90	
	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when perform (Anaes.) (Assist.)	
30023	(See para TN.8.6 of explanatory notes to this Category) Fee: \$331.25 Benefit: 75% = \$248.45 85% = \$281.60	
	WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical Gangrene, under general anaesthesia or regional or field nerve block, including when performed (Anaes.) (Assist.)	
30024	Fee: \$331.25 Benefit: 75% = \$248.45 85% = \$281.60	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPA other than wound closure at time of surgery, not on face or neck, small (NOT M LONG), superficial, not being a service to which another item in Group T4 appl	ORE THAN 7 CM
30026	(See para TN.8.6 of explanatory notes to this Category) Fee: \$53.05 Benefit: 75% = \$39.80 85% = \$45.10	
30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPA other than wound closure at time of surgery, not on face or neck, small (NOT M	

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	LONG), involving deeper tissue, not being a service to which another item in Gr	roup T4 applies (Anaes.)
	(See para TN.8.6 of explanatory notes to this Category) Fee: \$91.45 Benefit: 75% = \$68.60 85% = \$77.75	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAI other than wound closure at time of surgery, on face or neck, small (NOT MORI superficial (Anaes.)	
30032	(See para TN.8.6 of explanatory notes to this Category) Fee: \$83.80 Benefit: 75% = \$62.85 85% = \$71.25	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAI other than wound closure at time of surgery, on face or neck, small (NOT MORI involving deeper tissue (Anaes.)	
30035	(See para TN.8.6 of explanatory notes to this Category) Fee: \$119.45 Benefit: 75% = \$89.60 85% = \$101.55	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAI other than wound closure at time of surgery, not on face or neck, large (MORE 7 superficial, not being a service to which another item in Group T4 applies (Anae	THAN 7 CM LONG),
30038	(See para TN.8.6 of explanatory notes to this Category) Fee: \$91.45 Benefit: 75% = \$68.60 85% = \$77.75	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAI other than wound closure at time of surgery, other than on face or neck, large (M LONG), involving deeper tissue, other than a service to which another item in G (Anaes.)	IORE THAN 7 CM
30042	(See para TN.8.6 of explanatory notes to this Category) Fee: \$188.55 Benefit: 75% = \$141.45 85% = \$160.30	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAI other than wound closure at time of surgery, on face or neck, large (MORE THA superficial (Anaes.)	
30045	(See para TN.8.6 of explanatory notes to this Category) Fee: \$119.45 Benefit: 75% = \$89.60 85% = \$101.55	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAI other than wound closure at time of surgery, on face or neck, large (MORE THA involving deeper tissue (Anaes.)	
30049	(See para TN.8.6 of explanatory notes to this Category) Fee: \$188.55 Benefit: 75% = \$141.45 85% = \$160.30	
	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair apposition of each layer of tissue (Anaes.) (Assist.)	of, with accurate
30052	Fee: \$258.05 Benefit: 75% = \$193.55 85% = \$219.35	
	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal service associated with a service to which another item in this Group applies (Ar	
30055	Fee: \$75.10 Benefit: 75% = \$56.35 85% = \$63.85	
	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, a procedure (Anaes.)	s an independent
30058		

T8. SUF	URGICAL OPERATIONS 1. GE		1. GENERAL
	Fee: \$146.65	Benefit: 75% = \$110.00 85% = \$124.70	
	SUPERFICIAL independent proc	FOREIGN BODY, REMOVAL OF, (including from cornea or cedure (Anaes.)	r sclera), as an
30061	Fee: \$23.90	Benefit: 75% = \$17.95 85% = \$20.35	
	Etonogestrel sub	cutaneous implant, removal of, as an independent procedure (A	Anaes.)
30062	Fee: \$61.70	Benefit: 75% = \$46.30 85% = \$52.45	
		US FOREIGN BODY, removal of, requiring incision and explormed, as an independent procedure (Anaes.)	loration, including closure
30064	Fee: \$111.65	Benefit: 75% = \$83.75 85% = \$94.95	
	FOREIGN BOD procedure (Anae	Y IN MUSCLE, TENDON OR OTHER DEEP TISSUE, remo s.) (Assist.)	oval of, as an independent
30068	Fee: \$281.25	Benefit: 75% = \$210.95 85% = \$239.10	
	Diagnostic biops examination (An	y of skin, as an independent procedure, if the biopsy specimen aes.)	is sent for pathological
30071	Fee: \$53.05	of explanatory notes to this Category) Benefit: 75% = \$39.80 85% = \$45.10 care Safety Net Cap: \$42.45	
	Diagnostic biops	y of mucous membrane, as an independent procedure, if the bi mination (Anaes.)	opsy specimen is sent for
30072	(See para TN.8.7 c Fee: \$53.05	of explanatory notes to this Category) Benefit: $75\% = 39.80 $85\% = 45.10	
		BIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP T procedure, if the biopsy specimen is sent for pathological exam	
30075	Fee: \$152.15	Benefit: 75% = \$114.15 85% = \$129.35	
		DRILL BIOPSY OF LYMPH NODE, DEEP TISSUE OR ORO e the biopsy specimen is sent for pathological examination (An	
30078	(See para TN.8.7 c Fee: \$49.25	of explanatory notes to this Category) Benefit: 75% = \$36.95 85% = \$41.90	
		BIOPSY OF BONE MARROW by trephine using open approa for pathological examination (Anaes.)	ch, where the biopsy
30081	(See para TN.8.7 c Fee: \$111.65	of explanatory notes to this Category) Benefit: 75% = \$83.75 85% = \$94.95	
		BIOPSY OF BONE MARROW by trephine using percutaneou r pathological examination (Anaes.)	s approach where the
30084	(See para TN.8.7 c Fee: \$59.75	of explanatory notes to this Category) Benefit: $75\% = 44.85 $85\% = 50.80	
		BIOPSY OF BONE MARROW by aspiration or PUNCH BIOD where the biopsy is sent for pathological examination (Anaes.)	PSY OF SYNOVIAL
30087	(See para TN.8.7 c Fee: \$29.90	of explanatory notes to this Category) Benefit: $75\% = 22.45 $85\% = 25.45	

T8. SUF	RGICAL OPERAT	IONS		1. GENERAL
		BIOPSY OF PLEURA, PERC t for pathological examination	CUTANEOUS 1 or more biopsies on an (Anaes.)	ny 1 occasion, where
30090	(See para TN.8.7 c Fee: \$130.60	of explanatory notes to this Categ Benefit: 75% = \$97.95		
	DIAGNOSTIC N examination (An		EBRA, where the biopsy is sent for pa	thological
30093	(See para TN.8.7 c Fee: \$174.30	of explanatory notes to this Categ Benefit: 75% = \$130.75		
			TION BIOPSY of deep organ using int the biopsy is sent for pathological exa	
30094	(See para TN.8.7 c Fee: \$192.45	of explanatory notes to this Categ Benefit: 75% = \$144.35		
		CALENE NODE BIOPSY, t mination (Anaes.)	by open procedure, where the specimen	n excised is sent for
30096	(See para TN.8.7 c Fee: \$186.85	of explanatory notes to this Categ Benefit: 75% = \$140.15	•	
			tion Test, including associated consult cess to facilities where life support pro-	
	greater	than 100 nmol/L but less than	any day in the preceding month has b 400 nmol/L; or d adrenal insufficiency is suspected.	een measured at
30097	(See para TN.8.13 Fee: \$98.70	9 of explanatory notes to this Cat Benefit: $75\% = \$74.05$ 8		
	SINUS, excision	of, involving superficial tissu	ue only (Anaes.)	
30099	Fee: \$91.45	Benefit: 75% = \$68.60 8	35% = \$77.75	
	SINUS, excision	of, involving muscle and dee	ep tissue (Anaes.)	
30103	Fee: \$186.85	Benefit: 75% = \$140.15	85% = \$158.85	
	PRE-AURICUL	AR SINUS, on a person 10 ye	ears of age or over. Excision of, (Anae	es.)
30104	Fee: \$128.95	Benefit: 75% = \$96.75	35% = \$109.65	
			r 10 years of age. Excision of, (Anaes	.)
30105	Fee: \$167.60	Benefit: 75% = \$125.70	85% = \$142.50	
	GANGLION OF		of, other than a service associated with	a service to which
30107	Fee: \$223.45	Benefit: 75% = \$167.60	85% = \$189.95	
	BURSA (LARG (Assist.)	E), INCLUDING OLECRAN	ION, CALCANEUM OR PATELLA,	excision of (Anaes.)
30111	Fee: \$377.45	Benefit: 75% = \$283.10	85% = \$320.85	
30114	BURSA, SEMIN	IEMBRANOSUS (Baker's cy	yst), excision of (Anaes.) (Assist.)	

T8. SUF	GICAL OPERATIONS	1. GENERAL
	Fee: \$377.45 Benefit: 75% = \$283.10	
	Lipectomy, wedge excision of abdominal apron that is a direct consequence of signi not being a service associated with a service to which item 30168, 30171, 30172, 30 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has conventional (or non surgical) treatment; and	s failed 3 months of
	(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 lipectomy	prior to the
	(H) (Anaes.) (Assist.)	
30165	(See para TN.8.8 of explanatory notes to this Category) Fee: \$462.15 Benefit: 75% = \$346.65	
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct significant weight loss, not being a service associated with a service to which item 3 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 ha conventional (or non surgical) treatment; and	as failed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss lipectomy; and	prior to the
	(d) the procedure involves 1 excision only	
	(H) (Anaes.) (Assist.)	
30168	(See para TN.8.8 of explanatory notes to this Category) Fee: \$462.15 Benefit: 75% = \$346.65	
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct significant weight loss, not being a service associated with a service to which item 3 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	-
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has conventional (or non surgical) treatment; and	as failed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss lipectomy; and	prior to the
	(d) the procedure involves 2 excisions only	
	(H) (Anaes.) (Assist.)	
30171	(See para TN.8.8 of explanatory notes to this Category) Fee: \$702.80 Benefit: 75% = \$527.10	
30172	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct significant weight loss, not being a service associated with a service to which item 3	

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has conventional (or non surgical) treatment; and	failed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss p lipectomy; and	rior to the
	(d) the procedure involves 3 or more excisions	
	(H) (Anaes.) (Assist.)	
	(See para TN.8.8 of explanatory notes to this Category) Fee: \$702.80 Benefit: 75% = \$527.10	
	Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin at tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a with a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 4556 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour s (Anaes.) (Assist.)	service associated 54 or 45565
30176	(See para TN.8.8 of explanatory notes to this Category) Fee: \$1,001.45 Benefit: 75% = \$751.10	
	Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdom that is a direct consequence of significant weight loss, in conjunction with a radical ab (Pitanguy type or similar), with or without repair of musculoaponeurotic layer and tran umbilicus, not being a service associated with a service to which item 30165, 30168, 3 30176, 30179, 45530, 45564 or 45565 applies, if:	dominoplasty nsposition of
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has conventional (or non surgical) treatment; and	failed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss p lipectomy	rior to the
	(H) (Anaes.) (Assist.)	
30177	(See para TN.8.8 of explanatory notes to this Category) Fee: \$1,001.45 Benefit: 75% = \$751.10	
	Circumferential lipectomy, as an independent procedure, to correct circumferential ex- skin and fat that is a direct consequence of significant weight loss, with or without a ra abdominoplasty (Pitanguy type or similar), not being a service associated with a servi 30165, 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if:	adical
	(a) the circumferential excess of redundant skin and fat is complicated by intertrigo or condition that risks loss of skin integrity and has failed 3 months of conventional (or n treatment; and	
	(b) the circumferential excess of redundant skin and fat interferes with the activities of	f daily living; and
30179	(c) the weight has been stable for at least 6 months following significant weight loss p	rior to the

T8. SUF	RGICAL OPERATIONS 1. GENERA	٩L
	lipectomy	
	(H) (Anaes.) (Assist.)	
	(See para TN.8.8 of explanatory notes to this Category) Fee: \$1,232.55 Benefit: 75% = \$924.45	
	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.)	
30180	Fee: \$138.70 Benefit: 75% = \$104.05 85% = \$117.90	
	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.)	
30183	Fee: \$250.45 Benefit: 75% = \$187.85 85% = \$212.90	
	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital, or when performed by a specialist in the practice of his/her specialty, (5 or mor warts) (Anaes.)	re
30187	(See para TN.8.9 of explanatory notes to this Category) Fee: \$261.05 Benefit: 75% = \$195.80 85% = \$221.90	
	WARTS or MOLLUSCUM CONTAGIOSUM (one or more), removal of, by any method (other than b chemical means), where undertaken in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (H) (Anaes.)	
30189	(See para TN.8.9 of explanatory notes to this Category) Fee: \$149.65 Benefit: 75% = \$112.25	
	Angiofibromas, trichoepitheliomas or other severely disfiguring tumours of the face or neck (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), suitable for laser ablation as confirmed by the opinion of a specialist in the specialty of dermatology—removal of, by carbon dioxide laser or erbium laser ablation, including associated resurfacing (10 or more tumours) (Anaes.)	
30190	Fee: \$404.10 Benefit: 75% = \$303.10 85% = \$343.50	
	Angiofibromas, trichoepithelioma, epidermal naevi, xanthelasma, pyogenic granuloma, genital angiokeratomas, hereditary haemorrhagic telangiectasia and other severely disfiguring or recurrently bleeding tumours (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), treatment of, with carbon dioxide/erbium or other appropriate laser (or curettage and fine point diathermy for pyogenic granuloma only), if confirmed by the opinion of a specialist in the specialty of dermatology, one or more lesions.	m
30191	Fee: \$64.50 Benefit: 75% = \$48.40 85% = \$54.85	
	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (1 or more lesions) (Anaes.)	0
30192	(See para TN.8.9 of explanatory notes to this Category)Fee: $$40.20$ Benefit: $75\% = 30.15 $85\% = 34.20	
	Malignant neoplasm of skin or mucous membrane that has been:	
	(a) proven by histopathology; or	
	(b) confirmed by the opinion of a specialist in the specialty of dermatology where a specimen has been submitted for histologic confirmation;	l
30196	removal of, by serial curettage, or carbon dioxide laser or erbium laser excision-ablation, including any	v

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	associated cryotherapy or diathermy (Anaes.)	
	(See para TN.8.10 of explanatory notes to this Category) Fee: \$128.30 Benefit: 75% = \$96.25 85% = \$109.10	
	Malignant neoplasm of skin or mucous membrane proven by histopathology or con of a specialist in the specialty of dermatology—removal of, by liquid nitrogen cryo freeze thaw cycles	
30202	(See para TN.8.10 of explanatory notes to this Category) Fee: \$49.10 Benefit: 75% = \$36.85 85% = \$41.75	
	Skin lesions, multiple injections with glucocorticoid preparations (Anaes.)	
30207	Fee: \$45.30 Benefit: 75% = \$34.00 85% = \$38.55	
	Keloid and other skin lesions, extensive, multiple injections of glucocorticoid prepa in the operating theatre of a hospital on a patient less than 16 years of age (Anaes.)	arations, if undertaken
30210	Fee: \$165.55 Benefit: 75% = \$124.20	
	HAEMATOMA, aspiration of (Anaes.)	
30216	Fee: \$27.80 Benefit: 75% = \$20.85 85% = \$23.65	
	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not re a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)	quiring admission to
30219	(See para TN.8.4 of explanatory notes to this Category) Fee: \$27.80 Benefit: 75% = \$20.85 85% = \$23.65	
	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or si requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding at	
30223	(See para TN.8.4 of explanatory notes to this Category) Fee: \$165.55 Benefit: 75% = \$124.20	
	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imagin not including imaging (Anaes.)	ng techniques - but
30224	Fee: \$241.40 Benefit: 75% = \$181.05 85% = \$205.20	
	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniqu imaging (Anaes.)	ues - but not including
30225	Fee: \$271.95 Benefit: 75% = \$204.00 85% = \$231.20	
	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.)	
30226	Fee: \$152.15 Benefit: 75% = \$114.15 85% = \$129.35	
	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.)	
30229	Fee: \$277.30 Benefit: 75% = \$208.00 85% = \$235.75	
56229	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (A	maes.)
20222		
30232	Fee: \$227.20Benefit: 75% = \$170.4085% = \$193.15MUSCLE, RUPTURED, repair of (extensive), not associated with external wound	(Anaes) (Assist)
		(AIIacs.) (ASSISI.)
30235	Fee: \$300.45 Benefit: 75% = \$225.35 85% = \$255.40	

T8. SUF	RGICAL OPERAT	IONS 1. GENERAL	
	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.)		
30238	Fee: \$152.15	Benefit: 75% = \$114.15 85% = \$129.35	
	BONE TUMOU applies (Anaes.)	R, INNOCENT, excision of, not being a service to which another item in this Group (Assist.)	
30241	Fee: \$362.05	Benefit: 75% = \$271.55 85% = \$307.75	
	STYLOID PROC	CESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.)	
30244	Fee: \$362.05	Benefit: 75% = \$271.55	
	PAROTID DUC	T, repair of, using micro-surgical techniques (Anaes.) (Assist.)	
30246	Fee: \$700.85	Benefit: 75% = \$525.65	
	PAROTID GLA	ND, total extirpation of (Anaes.) (Assist.)	
30247	Fee: \$751.20	Benefit: 75% = \$563.40	
	PAROTID GLA	ND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.)	
30250	Fee: \$1,271.10	Benefit: 75% = \$953.35	
	RECURRENT P	AROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.)	
30251	Fee: \$1,952.50	Benefit: 75% = \$1464.40 85% = \$1867.80	
	PAROTID GLA (Assist.)	ND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.)	
30253	Fee: \$847.40	Benefit: 75% = \$635.55	
	SUBMANDIBU	LAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.)	
30255	Fee: \$1,128.40	Benefit: 75% = \$846.30	
	SUBMANDIBU	LAR GLAND, extirpation of (Anaes.) (Assist.)	
30256	Fee: \$452.55	Benefit: 75% = \$339.45	
	SUBLINGUAL	GLAND, extirpation of (Anaes.)	
30259	Fee: \$201.70	Benefit: 75% = \$151.30 85% = \$171.45	
	SALIVARY GL	AND, DILATATION OR DIATHERMY of duct (Anaes.)	
30262	Fee: \$59.75	Benefit: 75% = \$44.85 85% = \$50.80	
	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.)		
30266	Fee: \$152.15	Benefit: 75% = \$114.15 85% = \$129.35	
	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.)		
30269	Fee: \$152.15	Benefit: 75% = \$114.15 85% = \$129.35	
		ll excision of (Anaes.) (Assist.)	
30272	Fee: \$300.45	Benefit: 75% = \$225.35 85% = \$255.40	
30275		ISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE	

T8. SUF	GICAL OPERATION	DNS 1. GENER	۱A۶	
	AND LYMPH NODES OF NECK (commandotype operation) (Anaes.) (Assist.)			
	Fee: \$1,790.95	Benefit: 75% = \$1343.25		
	TONGUE TIE, re	pair of, not being a service to which another item in this Group applies (Anaes.)		
30278	Fee: \$47.25	Benefit: 75% = \$35.45 85% = \$40.20		
	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person			
	aged 2 years and o	ver, under general anaesthesia (Anaes.)		
30281	Fee: \$121.40	Benefit: 75% = \$91.05 85% = \$103.20		
	RANULA OR MU	JCOUS CYST OF MOUTH, removal of (Anaes.)		
30283	Fee: \$208.00	Benefit: 75% = \$156.00 85% = \$176.80		
	BRANCHIAL CY	ST, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.)		
30286	Fee: \$404.20	Benefit: 75% = \$303.15 85% = \$343.60		
00200		'ST, on a person under 10 years of age. Removal of, (Anaes.) (Assist.)		
30287	Fee: \$525.50	Benefit: 75% = \$394.15 85% = \$446.70		
30287		STULA, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.)		
30289	Fee: \$510.30	Benefit: 75% = \$382.75		
		OPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or pair (Anaes.) (Assist.)		
30293	Fee: \$452.55	Benefit: 75% = \$339.45 85% = \$384.70		
		OPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction	;	
30294	Fee: \$1,790.95	Benefit: 75% = \$1343.25		
	THYROIDECTO	MY, total (Anaes.) (Assist.)		
30296	-	of explanatory notes to this Category) Benefit: 75% = \$780.10		
00200		MY following previous thyroid surgery (Anaes.) (Assist.)		
	(See para TN 8-138	of explanatory notes to this Category)		
30297	Fee: \$1,040.10	Benefit: $75\% = \$780.10$		
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) (Assist.)			
30299	(See para TN.8.12 o Fee: \$647.65	f explanatory notes to this Category) Benefit: 75% = \$485.75		
	II/III axilla, using	PH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a leve preoperative lymphoscintigraphy and lymphotropic dye injection, not being a servic service to which item 30299, 30302 or 30303 applies (Anaes.) (Assist.)		
30300	(See para TN.8.12 o Fee: \$777.15	f explanatory notes to this Category) Benefit: 75% = \$582.90		

T8. SUR	GICAL OPERATIONS	1. GENERAL
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving di axilla, using lymphotropic dye injection, not being a service associated with a service 30299, 30300 or 30303 applies (Anaes.) (Assist.)	
30302	(See para TN.8.12 of explanatory notes to this Category) Fee: \$518.10 Benefit: 75% = \$388.60	
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving di II/III axilla, using lymphotropic dye injection, not being a service associated with a s item 30299, 30300 or 30302 applies (Anaes.) (Assist.)	
30303	(See para TN.8.12 of explanatory notes to this Category) Fee: \$621.65 Benefit: 75% = \$466.25	
	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.)	
30306	(See para TN.8.137, TN.8.138 of explanatory notes to this Category) Fee: \$811.45 Benefit: 75% = \$608.60	
	Partial or subtotal thyroidectomy (Anaes.) (Assist.)	
30310	(See para TN.8.137 of explanatory notes to this Category) Fee: \$811.45 Benefit: 75% = \$608.60	
	THYROGLOSSAL CYST or FISTULA or both, on a person 10 years of age or over of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.)	Radical removal
30314	Fee: \$464.70 Benefit: 75% = \$348.55	
	Minimally invasive parathyroidectomy. Removal of 1 or more parathyroid adenoma cervical incision for an image localised adenoma, including thymectomy.	through a small
	For any particular patient - applicable only once per occasion on which the service is	provided.
	Not in association with a service to which item 30318, 30317 or 30320 applies. (Ana	nes.) (Assist.)
30315	Fee: \$1,158.15 Benefit: 75% = \$868.65	
	Redo parathyroidectomy. Cervical re-exploration for persistent or recurrent hyperpar including thymectomy and cervical exploration of the mediastinum.	athyroidism,
	For any particular patient - applicable only once per occasion on which the service is	s provided.
	Not in association with a service to which item 30315, 30318 or 30320 applies. (Ana	es.) (Assist.)
30317	Fee: \$1,386.75 Benefit: 75% = \$1040.10	
	Open parathyroidectomy, exploration and removal of 1 or more adenoma or hyperpla cervical incision including thymectomy and cervical exploration of the mediastinum	
	For any particular patient - applicable only once per occasion on which the service is	s provided.
	Not in association with a service to which item 30315, 30317 or 30320 applies. (Ana	es.) (Assist.)
30318	Fee: \$1,158.15 Benefit: 75% = \$868.65	
	Removal of a mediastinal parathyroid adenoma via sternotomy or mediastinal thoras	copic approach.
30320	For any particular patient - applicable only once per occasion on which the service is	s provided.

T8. SUF	GICAL OPERATION	ONS	1. GENERAL
	Not in association	with a service to which item 30315, 30317 or 30318 applies. (An	naes.) (Assist.)
	Fee: \$1,386.75	Benefit: 75% = \$1040.10	
	Excision of phaeo (Anaes.) (Assist.)	chromocytoma or extraadrenal paraganglioma via endoscopic or	open approach.
30323	Fee: \$1,386.75	Benefit: 75% = \$1040.10	
	Excision of an adu	renocortical tumour or hyperplasia via endoscopic or open approa	ach. (Anaes.) (Assist.)
30324	Fee: \$1,386.75	Benefit: 75% = \$1040.10	
		L CYST or FISTULA or both, radical removal of, including thyr one, on a person under 10 years of age (Anaes.) (Assist.)	roglossal duct and
30326	Fee: \$604.10	Benefit: 75% = \$453.10	
	LYMPH NODES	of GROIN, limited excision of (Anaes.)	
30329	Fee: \$250.90	Benefit: 75% = \$188.20 85% = \$213.30	
	LYMPH NODES	of GROIN, radical excision of (Anaes.) (Assist.)	
30330	Fee: \$730.25	Benefit: 75% = \$547.70	
	LYMPH NODES	of AXILLA, limited excision of (sampling) (Anaes.) (Assist.)	
30332	Fee: \$352.30	Benefit: 75% = \$264.25	
		of AXILLA, complete excision of, to level I (Anaes.) (Assist.)	
30335	(See para TN.8.13 c Fee: \$880.70	of explanatory notes to this Category) Benefit: 75% = \$660.55	
	LYMPH NODES	of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.)
30336	(See para TN.8.13 c Fee: \$1,056.90	of explanatory notes to this Category) Benefit: 75% = \$792.70	
	LAPAROTOMY is performed (Ana	(exploratory), including associated biopsies, where no other intra nes.) (Assist.)	a-abdominal procedure
30373	Fee: \$491.00	Benefit: 75% = \$368.25	
	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, on a person 10 years of age or over. Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvul Pyloroplasty (adult) or Drainage of pancreas (Anaes.) (Assist.)		moval of Meckel's
30375	(See para TN.8.14 c Fee: \$529.60	of explanatory notes to this Category) Benefit: 75% = \$397.20	
		INVOLVING DIVISION OF PERITONEAL ADHESIONS (wh ocedure is performed) on a person 10 years of age or over (Anaes	
30376	Fee: \$529.60	Benefit: 75% = \$397.20	
		involving division of adhesions in conjunction with another intra ken to divide the adhesions is between 45 minutes and 2 hours, or s.) (Assist.)	
30378	Fee: \$532.10	Benefit: 75% = \$399.10	

T8. SUF	RGICAL OPERATION	ONS	1. GENERAL
		WITH DIVISION OF EXTENSIVE ADHESIONS (dur sertion of long intestinal tube (Anaes.) (Assist.)	ration greater than 2 hours)
30379	Fee: \$943.00	Benefit: 75% = \$707.25	
	ENTEROCUTAN bowel (Anaes.) (A	NEOUS FISTULA, radical repair of, involving extensive Assist.)	e dissection and resection of
30382	Fee: \$1,327.80	Benefit: 75% = \$995.85	
		FOR GRADING OF LYMPHOMA, including splenect oophoropexy (Anaes.) (Assist.)	omy, liver biopsies, lymph
30384	Fee: \$1,117.00	Benefit: 75% = \$837.75	
		FOR CONTROL OF POSTOPERATIVE HAEMORRH ormed (Anaes.) (Assist.)	HAGE, where no other
30385	Fee: \$572.30	Benefit: 75% = \$429.25	
		INVOLVING OPERATION ON ABDOMINAL VISCI e to which another item in this Group applies (Anaes.) (
30387	Fee: \$645.15	Benefit: 75% = \$483.90	
	LAPAROTOMY	for trauma involving 3 or more organs (Anaes.) (Assist.)
30388	Fee: \$1,623.10	Benefit: 75% = \$1217.35	
	person 10 years of	, diagnostic, not being a service associated with any oth f age or over (Anaes.)	er laparoscopic procedure, on a
30390	(See para TN.8.15 c Fee: \$223.45	of explanatory notes to this Category) Benefit: 75% = \$167.60	
50570		with biopsy (Anaes.) (Assist.)	
30391	Fee: \$288.90	Benefit: 75% = \$216.70	
50591	RADICAL OR D	EBULKING OPERATION for advanced intra-abdomin an independent procedure (Anaes.) (Assist.)	al malignancy, with or without
30392	Fee: \$685.30	Benefit: 75% = \$514.00	
		C DIVISION OF ADHESIONS in association with another to divide the adhesions exceeds 45 minutes (Anaes.)	-
30393	Fee: \$532.10	Benefit: 75% = \$399.10	
		for drainage of subphrenic abscess, pelvic abscess, apper eritonitis from any cause, with or without appendicecton	
30394	Fee: \$500.75	Benefit: 75% = \$375.60	
	removal of foreig	for gross intra peritoneal sepsis requiring debridement of n material or enteric contents, with lavage of the entire p n, with or without closure of abdomen and with or witho	peritoneal cavity via a major
30396	(See para TN.8.16 c Fee: \$1,032.80	of explanatory notes to this Category) Benefit: 75% = \$774.60	
30397	LAPAROSTOMY	Y, via wound previously made and left open or closed w	ith zipper, involving change of

T8. SUF	RGICAL OPERATIO	NS 1. GENERA		
	dressings or packs,	and with or without drainage of loculated collections (Anaes.)		
	Fee: \$236.05	Benefit: 75% = \$177.05		
		final closure of wound made at previous operation, after removal of dressings or of mesh or zipper if previously inserted (Anaes.) (Assist.)		
30399	Fee: \$324.70	Benefit: 75% = \$243.55		
		/ITH INSERTION OF PORTACATH for administration of cytotoxic therapy t of reservoir (Anaes.) (Assist.)		
30400	Fee: \$642.60	Benefit: 75% = \$481.95		
	RETROPERITON	EAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.)		
30402	Fee: \$472.05	Benefit: 75% = \$354.05		
	VENTRAL, INCIS without mesh (Ana	IONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or es.) (Assist.)		
30403	Fee: \$529.60	Benefit: 75% = \$397.20		
		CISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, insposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.)		
30405	Fee: \$929.60	Benefit: 75% = \$697.20		
	PARACENTESIS ABDOMINIS (Anaes.)			
30406	Fee: \$53.05	Benefit: 75% = \$39.80 85% = \$45.10		
	PERITONEOVEN	DUS shunt, insertion of (Anaes.) (Assist.)		
30408	Fee: \$398.35	Benefit: 75% = \$298.80		
	LIVER BIOPSY, p	ercutaneous (Anaes.)		
30409	Fee: \$177.25	Benefit: 75% = \$132.95 85% = \$150.70		
	LIVER BIOPSY by procedure (Anaes.)	wedge excision when performed in conjunction with another intraabdominal		
30411	Fee: \$90.20	Benefit: 75% = \$67.65		
	LIVER BIOPSY by (Anaes.)	core needle, when performed in conjunction with another intra-abdominal procedu		
30412	Fee: \$53.20	Benefit: 75% = \$39.90 85% = \$45.25		
	LIVER, subsegmen	tal resection of, (local excision), other than for trauma (Anaes.) (Assist.)		
30414	Fee: \$700.85	Benefit: 75% = \$525.65		
	LIVER, segmental	resection of, other than for trauma (Anaes.) (Assist.)		
30415	Fee: \$1,401.55	Benefit: 75% = \$1051.20		
		roscopic marsupialisation of, where the size of the cyst is greater than 5cm in		
30416	Fee: \$760.95	Benefit: 75% = \$570.75		
30417	LIVER CYSTS, lap	aroscopic marsupialisation of 5 or more, including any cyst greater than 5cm in		

T8. SUF	GICAL OPERATIO	NS 1. GENERA
	diameter (Anaes.)	Assist.)
	Fee: \$1,141.35	Benefit: 75% = \$856.05
	LIVER, lobectomy	of, other than for trauma (Anaes.) (Assist.)
30418	Fee: \$1,623.10	Benefit: 75% = \$1217.35
		S, destruction of, by hepatic cryotherapy, not being a service associated with a service of or 50952 applies (Anaes.) (Assist.)
30419	Fee: \$830.15	Benefit: 75% = \$622.65 85% = \$745.45
	LIVER, TRI-SEGN (Assist.)	MENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.)
30421	Fee: \$2,028.50	Benefit: 75% = \$1521.40
	LIVER, repair of s	uperficial laceration of, for trauma (Anaes.) (Assist.)
30422	Fee: \$686.15	Benefit: 75% = \$514.65
	LIVER, repair of d	eep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.)
30425	Fee: \$1,327.80	Benefit: 75% = \$995.85
	LIVER, segmental	resection of, for trauma (Anaes.) (Assist.)
30427	Fee: \$1,585.95	Benefit: 75% = \$1189.50
		of, for trauma (Anaes.) (Assist.)
30428	Fee: \$1,696.70	Benefit: 75% = \$1272.55 85% = \$1612.00
20.20		obectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.)
30430	Fee: \$2,360.45	Benefit: 75% = \$1770.35 85% = \$2275.75
		, open abdominal drainage of (Anaes.) (Assist.)
30431	Fee: \$529.60	Benefit: 75% = \$397.20 85% = \$450.20
00.01		(multiple), open abdominal drainage of (Anaes.) (Assist.)
30433	Fee: \$737.65	Benefit: 75% = \$553.25
	HYDATID CYST	OF LIVER, peritoneum or viscus, complete removal of contents of, with or without dicles (Anaes.) (Assist.)
30434	Fee: \$597.55	Benefit: 75% = \$448.20
		OF LIVER, peritoneum or viscus, complete removal of contents of, with or without dicles, with omentoplasty or myeloplasty (Anaes.) (Assist.)
30436	Fee: \$663.90	Benefit: 75% = \$497.95
	HYDATID CYST (Anaes.) (Assist.)	OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall)
30437	Fee: \$826.30	Benefit: 75% = \$619.75
	HYDATID CYST	OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.)
30438	Fee: \$1,169.25	Benefit: 75% = \$876.95 85% = \$1084.55

T8. SUF	RGICAL OPERAT	FIONS	1. GENERAL
	OPERATIVE U	CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAULE JLTRASOUND of the biliary tract (including 1 or more exami (Anaes.) (Assist.)	
30439	Fee: \$188.55	Benefit: 75% = \$141.45	
	interventional in	GRAM, percutaneous transhepatic, and insertion of biliary drain naging techniques - but not including imaging, not being a ser titem 30451 applies (Anaes.) (Assist.)	
30440	Fee: \$534.80	Benefit: 75% = \$401.10 85% = \$454.60	
	INTRA OPERA	ATIVE ULTRASOUND for staging of intra abdominal tumour	rs (Anaes.)
30441	Fee: \$138.45	Benefit: 75% = \$103.85	
	CHOLEDOCHO	OSCOPY in conjunction with another procedure (Anaes.)	
30442	Fee: \$188.55	Benefit: 75% = \$141.45	
	CHOLECYSTE	ECTOMY (Anaes.) (Assist.)	
30443	Fee: \$751.20	Benefit: 75% = \$563.40	
50445		PIC CHOLECYSTECTOMY (Anaes.) (Assist.)	
30445	Fee: \$751.20	Benefit: 75% = \$563.40	1 ()
	(Assist.)	PIC CHOLECYSTECTOMY when procedure is completed by	laparotomy (Anaes.)
30446	Fee: \$751.20	Benefit: 75% = \$563.40	
	LAPAROSCOP duct (Anaes.) (A	PIC CHOLECYSTECTOMY, involving removal of common of Assist.)	duct calculi via the cystic
30448	Fee: \$988.45	Benefit: 75% = \$741.35	
		PIC CHOLECYSTECTOMY with removal of common duct cay (Anaes.) (Assist.)	alculi via laparoscopic
30449	Fee: \$1,099.15	Benefit: 75% = \$824.40	
		F BILIARY OR RENAL TRACT, extraction of, using interve vice associated with a service to which items 36627, 36630, 3	
30450	Fee: \$532.80	Benefit: 75% = \$399.60 85% = \$452.90	
	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not includ imaging, not being a service associated with a service to which item 30440 applies (Anaes.) (Assist.)		
30451	Fee: \$271.95	Benefit: 75% = \$204.00 85% = \$231.20	
	CHOLEDOCHO (Anaes.) (Assist	OSCOPY with balloon dilation of a stricture or passage of ster t.)	nt or extraction of calculi
30452	Fee: \$383.55	Benefit: 75% = \$287.70	
50452	i		
50452	CHOLEDOCHO (Assist.)	OTOMY (with or without cholecystectomy), with or without r	removal of calculi (Anaes.)

GICAL OPERATIONS	1. GENERAL
	r without cholecystectomy), with removal of calculi including biliary (Assist.)
Fee: \$1,030.25 Benefit: 7	5% = \$772.70
CHOLEDOCHOTOMY, intrah (Assist.)	epatic, involving removal of intrahepatic bile duct calculi (Anaes.)
Fee: \$1,401.55 Benefit: 7	5% = \$1051.20 $85% = 1316.85
calculi, sphincterotomy, sphinc	ION ON SPHINCTER OF ODDI, involving 1 or more of, removal of eroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, c duct, pancreatic duct septoplasty, with or without choledochotomy
Fee: \$1,030.25 Benefit: 7	5% = \$772.70
	OMY, CHOLECYSTOENTEROSTOMY, IY or Roux-en-Y as a bypass procedure when no prior biliary surgery
Fee: \$876.30 Benefit: 7	5% = \$657.25
	ta hepatis with biliary-enteric anastomoses, not being a service ch item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.) (Assist.)
Fee: \$1,502.05 Benefit: 7	5% = \$1126.55
RADICAL RESECTION of con anastomoses (Anaes.) (Assist.)	nmon hepatic duct and right and left hepatic ducts, with 2 duct
Fee: \$1,844.25 Benefit: 7	5% = \$1383.20
	amon hepatic duct and right and left hepatic ducts, involving more than gment or major portion of segment of liver (Anaes.) (Assist.)
Fee: \$2,213.10 Benefit: 7	5% = \$1659.85
INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.)	
Fee: \$1,276.15 Benefit: 7	5% = \$957.15
INTRAHEPATIC BYPASS of system (Anaes.) (Assist.)	ight hepatic ductal system by Roux-en-Y loop to peripheral ductal
Fee: \$1,578.55 Benefit: 7	5% = \$1183.95
BILIARY STRICTURE, repair	of, after 1 or more operations on the biliary tree (Anaes.) (Assist.)
Fee: \$1,748.45 Benefit: 7	5% = \$1311.35 85% = \$1663.75
HEPATIC OR COMMON BIL	E DUCT, repair of, as the primary procedure subsequent to partial or
Fee: \$944.20 Benefit: 7	5% = \$708.15 $85% = 859.50
gastroscopy, duodenoscopy or j	rvice to which item 41816 or 41822 applies), anendoscopy (1 or more such procedures), with or without biopsy, not a service to which item 30478 or 30479 applies. (Anaes.)
	CHOLEDOCHOTOMY (with orintestinal anastomosis (Anaes.) (Fee: \$1,030.25Benefit: 75CHOLEDOCHOTOMY, intrahe (Assist.)Fee: \$1,401.55Benefit: 75TRANSDUODENAL OPERAT calculi, sphincterotomy, sphincte sphincteroplasty of the pancreati (Anaes.) (Assist.)Fee: \$1,030.25Benefit: 75CHOLECYSTODUODENOSTOC CHOLEDOCHOJEJUNOSTOM performed (Anaes.) (Assist.)Fee: \$876.30Benefit: 75RADICAL RESECTION of port associated with a service to which associated with a service to mastomoses (Anaes.) (Assist.)Fee: \$1,502.05Benefit: 75RADICAL RESECTION of com anastomoses (Anaes.) (Assist.)Fee: \$1,276.15Benefit: 75INTRAHEPATIC biliary bypass system (Anaes.) (Assist.)Fee: \$1,276.15Benefit: 75BILIARY STRICTURE, repair of tystem (Anaes.) (Assist.)Fee: \$1,748.45Benefit: 75HEPATIC OR COMMON BILE total transection of bile duct or d assistFee: \$944.20Benefit: 75Oesophagoscopy (not being a se gastroscopy, duodenoscopy or paragements)

T8. SUF	RGICAL OPERATIONS	1. GENERA	
	Fee: \$179.95 Benefit: 75% = \$135.00 85% = \$153.00		
	Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use intensification where clinically indicated) (Anaes.)	e of imaging	
30475	(See para TN.8.17, TN.8.133 of explanatory notes to this Category) Fee: \$354.55 Benefit: 75% = \$265.95 85% = \$301.40		
	Oesophagoscopy (other than a service to which item 41816, 41822 or 41825 appl duodenoscopy, panendoscopy or push enteroscopy, one or more such procedures,		
	(a) the procedures are performed using one or more of the following endoscopic p	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 appli	es (Anaes.)	
30478	(See para TN.8.17 of explanatory notes to this Category) Fee: $$249.50$ Benefit: $75\% = 187.15 $85\% = 212.10		
30479	Endoscopy with laser therapy, for the treatment of one or more of the following:		

T8. SUF	RGICAL OPERATIONS 1.	GENERA
	(a) neoplasia;	
	(b) benign vascular lesions;	
	(c) strictures of the gastrointestinal tract;	
	(d) tumorous overgrowth through or over oesophageal stents;	
	(e) peptic ulcers;	
	(f) angiodysplasia;	
	(g) gastric antral vascular ectasia;	
	(h) post-polypectomy bleeding;	
	other than a service associated with a service to which item 30473 or 30478 applies (Anaes.)	
	(See para TN.8.17 of explanatory notes to this Category) Fee: \$483.70 Benefit: 75% = \$362.80 85% = \$411.15	
	PERCUTANEOUS GASTROSTOMY (initial procedure):	
	(a) including any associated imaging services; and	
	(b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)	
30481	(See para TN.8.17 of explanatory notes to this Category) Fee: \$362.70 Benefit: 75% = \$272.05 85% = \$308.30	
	PERCUTANEOUS GASTROSTOMY (repeat procedure):	
	(a) including any associated imaging services; and	
	(b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)	
30482	Fee: \$257.90 Benefit: 75% = \$193.45 85% = \$219.25	
	GASTROSTOMY BUTTON, CAECOSTOMY ANTEGRADE ENEMA DEVICE (CHAIT STOMAL INDWELLING DEVICE:	etc.) or
	(a) non-endoscopic insertion of; or	
	(b) non-endoscopic replacement of;	
	on a person 10 years of age or over, excluding the insertion of a device for the purpose of fac weight loss (Anaes.)	cilitating
30483	Fee: \$179.90 Benefit: 75% = \$134.95 85% = \$152.95	
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.)	
20494	(See para TN.8.17 of explanatory notes to this Category) East $\frac{1}{270}$ $\frac{1}{75}$ Barefit $\frac{750}{-5278}$ $\frac{10}{-5278}$ $\frac{10}{-5215}$ $\frac{15}{15}$	
30484	Fee: \$370.75Benefit: 75% = \$278.1085% = \$315.15ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bi	le duct
30485	(Anaes.)	ie uuet
30485	(Anaes.)	

T8. SUR	GICAL OPERATIONS	1. GENERAI
	(See para TN.8.17 of explanatory notes to this Category)	
	Fee: \$572.30 Benefit: 75% = \$429.25 85% = \$487.60	
	SMALL BOWEL INTUBATION as an independent procedure (Anaes.)	
30488	Fee: \$91.45 Benefit: 75% = \$68.60 85% = \$77.75	
	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilat	ation (Anaes.)
30490	(See para TN.8.17 of explanatory notes to this Category) Fee: \$534.80 Benefit: 75% = \$401.10 85% = \$454.60	
	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dila	tation) (Anaes.)
	(See para TN.8.17 of explanatory notes to this Category)	
30491	Fee: \$564.25 Benefit: 75% = \$423.20 85% = \$479.65	
	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when interventional imaging techniques - but not including imaging (Anaes.)	performed), using
30492	Fee: \$799.90 Benefit: 75% = \$599.95	
	ENDOSCOPIC BILIARY DILATATION (Anaes.)	
30494	(See para TN.8.17 of explanatory notes to this Category) Fee: \$427.25 Benefit: 75% = \$320.45	
	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using inter	ventional imaging
	techniques - but not including imaging (Anaes.)	
30495	Fee: \$799.90 Benefit: 75% = \$599.95	
	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenter	erostomy (Anaes.) (Assist.)
30496	Fee: \$597.55 Benefit: 75% = \$448.20 85% = \$512.85	
	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.)	
30497	Fee: \$712.50 Benefit: 75% = \$534.40	
	VAGOTOMY, highly selective (Anaes.) (Assist.)	
30499	Fee: \$847.40 Benefit: 75% = \$635.55	
	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anae	es.) (Assist.)
30500	Fee: \$907.40 Benefit: 75% = \$680.55 85% = \$822.70	
50500	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.)	
30502	Fee: \$1,001.45 Benefit: 75% = \$751.10	
30302	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previo	us operation for peptic
	ulcer (Anaes.) (Assist.)	
30503	Fee: \$1,121.45 Benefit: 75% = \$841.10 85% = \$1036.75	
	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point (Assist.)	or wedge excision (Anaes.)
30505	Fee: \$560.70 Benefit: 75% = \$420.55	
20504	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.)	or wedge excision, and
30506		

T8. SUF	JRGICAL OPERATIONS 1. GENE		
	Fee: \$981.20	Benefit: 75% = \$735.90	
		TIC ULCER, control of, involving suture of bleeding point or wedge excision, and agotomy (Anaes.) (Assist.)	
30508	Fee: \$1,032.80	Benefit: 75% = \$774.60	
	BLEEDING PEP (Anaes.) (Assist.)	TIC ULCER, control of, involving gastric resection (other than wedge resection)	
30509	Fee: \$1,032.80	Benefit: 75% = \$774.60 85% = \$948.10	
		y (including gastroduodenostomy) or enterocolostomy or enteroenterostomy, not bein a any of items 31569 to 31581 apply (Anaes.) (Assist.)	
30515	Fee: \$715.60	Benefit: 75% = \$536.70	
	GASTROENTER (Anaes.) (Assist.)	OSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of	
30517	Fee: \$936.95	Benefit: 75% = \$702.75	
	Partial gastrecton apply (Anaes.) (A	ny, not being a service associated with a service to which any of items 31569 to 3158 assist.)	
30518	Fee: \$1,003.30	Benefit: 75% = \$752.50	
	GASTRIC TUM (Anaes.) (Assist.)	DUR, removal of, by local excision, not being a service to which item 30518 applies	
30520	Fee: \$686.15	Benefit: 75% = \$514.65	
	GASTRECTOM	Y, TOTAL, for benign disease (Anaes.) (Assist.)	
30521	Fee: \$1,468.00	Benefit: 75% = \$1101.00	
	GASTRECTOM (Anaes.) (Assist.)	Y, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed)	
30523	(See para TN.8.18 o Fee: \$1,534.25	of explanatory notes to this Category) Benefit: 75% = \$1150.70	
		Y, TOTAL RADICAL, for carcinoma (including extended node dissection and distal nd splenectomy when performed) (Anaes.) (Assist.)	
30524	Fee: \$1,689.25	Benefit: 75% = \$1266.95	
		Y, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist	
30526	Fee: \$2,190.85	Benefit: 75% = \$1643.15	
		PERATION by fundoplasty, via abdominal or thoracic approach, with or without phragmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.)	
30527	(See para TN.8.19 o Fee: \$885.25	of explanatory notes to this Category) Benefit: 75% = \$663.95	
	ANTIREFLUX o (Anaes.) (Assist.)	peration by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophag	
30529	(See para TN.8.19 o Fee: \$1,327.80	of explanatory notes to this Category) Benefit: 75% = \$995.85	

T8. SUF	GICAL OPERATIONS	1. GENERAL
	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes	.) (Assist.)
30530	(See para TN.8.19 of explanatory notes to this Category) Fee: \$796.75 Benefit: 75% = \$597.60	
	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or without closure of the diaphragmatic hiatus, by laparoscopy or open operation	
30532	(See para TN.8.19 of explanatory notes to this Category) Fee: \$914.85 Benefit: 75% = \$686.15	
	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by lap (Anaes.) (Assist.)	
30533	(See para TN.8.19 of explanatory notes to this Category) Fee: \$1,088.15 Benefit: 75% = \$816.15	
	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisatio (Anaes.) (Assist.)	n and thoracotomy
30535	Fee: \$1,723.80 Benefit: 75% = \$1292.85	
	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobili anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.)	isation, thoracotomy and
30536	Fee: \$1,748.45 Benefit: 75% = \$1311.35	
	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobili anastomosis in the neck or chest- conjoint surgery, principal surgeon (includin (Assist.)	
30538	Fee: \$1,209.85 Benefit: 75% = \$907.40	
	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobili anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.)	isation, thoracotomy and
30539	Fee: \$885.25 Benefit: 75% = \$663.95	
	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdom anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (An	
30541	Fee: \$1,541.80 Benefit: 75% = \$1156.35	
	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdom anastomosis) with posterior or anterior mediastinal placement - conjoint surge (including aftercare) (Anaes.) (Assist.)	
30542	Fee: \$1,047.60 Benefit: 75% = \$785.70	
	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdom anastomosis) with posterior or anterior mediastinal placement - conjoint surge	
30544	Fee: \$767.30 Benefit: 75% = \$575.50	
	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and th thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.)	oracic mobilisation with
30545	Fee: \$1,866.50 Benefit: 75% = \$1399.90	
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and th	oracic mobilisation with

T8. SUF	RGICAL OPERAT	IONS	1. GENERAL	
	thoracic anastom	osis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.	.) (Assist.)	
	Fee: \$1,283.55	Benefit: 75% = \$962.70 85% = \$1198.85		
		TOMY with colon or jejunal anastomosis, (abdominal and thoracic molosis) - conjoint surgery, co-surgeon (Assist.)	bilisation with	
30548	Fee: \$958.90	Benefit: 75% = \$719.20 85% = \$874.20		
		TOMY with colon or jejunal replacement (abdominal and thoracic mob edicle in the neck) - 1 surgeon (Anaes.) (Assist.)	ilisation with	
30550	Fee: \$2,095.20	Benefit: 75% = \$1571.40		
		TOMY with colon or jejunal replacement (abdominal and thoracic mob edicle in the neck) - conjoint surgery, principal surgeon (including after		
30551	Fee: \$1,445.90	Benefit: 75% = \$1084.45		
		TOMY with colon or jejunal replacement (abdominal and thoracic mob edicle in the neck) - conjoint surgery, co-surgeon (Assist.)	ilisation with	
30553	Fee: \$1,069.50	Benefit: 75% = \$802.15 85% = \$984.80		
	OESOPHAGEC	TOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (A	Assist.)	
30554	Fee: \$2,331.15	Benefit: 75% = \$1748.40		
	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)			
30556	Fee: \$1,608.10	Benefit: 75% = \$1206.10		
	OESOPHAGEC	TOMY with reconstruction by free jejunal graft - conjoint surgery, co-s	surgeon (Assist.)	
30557	Fee: \$1,187.70	Benefit: 75% = \$890.80		
	OESOPHAGUS,	, local excision for tumour of (Anaes.) (Assist.)		
30559	Fee: \$863.15	Benefit: 75% = \$647.40 85% = \$778.45		
	OESOPHAGEA	L PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.)		
30560	Fee: \$958.90	Benefit: 75% = \$719.20		
		Y or COLOSTOMY, closure of (not involving resection of bowel), on ver (Anaes.) (Assist.)	a person 10	
30562	Fee: \$604.50	Benefit: 75% = \$453.40		
	COLOSTOMY ((Assist.)	OR ILEOSTOMY, refashioning of, on a person 10 years of age or over	(Anaes.)	
30563	Fee: \$604.50	Benefit: 75% = \$453.40 85% = \$519.80		
	SMALL BOWE	L STRICTUREPLASTY for chronic inflammatory bowel disease (Ana	es.) (Assist.)	
30564	Fee: \$784.65	Benefit: 75% = \$588.50		
	SMALL INTEST (Assist.)	FINE, resection of, without anastomosis (including formation of stoma)	(Anaes.)	
	Fee: \$885.25	Benefit: 75% = \$663.95		

T8. SUF	RGICAL OPERAT	IONS 1. GENERAL		
	SMALL INTES (Assist.)	FINE, resection of, with anastomosis, on a person 10 years of age or over (Anaes.)		
30566	Fee: \$983.35	Benefit: 75% = \$737.55		
	INTRAOPERAT (Assist.)	TIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.)		
30568	Fee: \$737.65	Benefit: 75% = \$553.25		
		EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, piopsies (Anaes.) (Assist.)		
30569	Fee: \$376.10	Benefit: 75% = \$282.10		
	APPENDICECT over (Anaes.) (A	OMY, not being a service to which item 30574 applies on a person 10 years of age or ssist.)		
30571	Fee: \$452.55	Benefit: 75% = \$339.45		
	LAPAROSCOP	C APPENDICECTOMY, on a person 10 years of age or over (Anaes.) (Assist.)		
30572	Fee: \$452.55	Benefit: 75% = \$339.45		
	NOTE: Multiple	Operation and Multiple Anaesthetic rules apply to this item		
	APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.)			
30574	Fee: \$125.20	Benefit: 75% = \$93.90		
	PANCREATIC dissection (Anae	ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic s.) (Assist.)		
30575	Fee: \$520.90	Benefit: 75% = \$390.70		
		NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.)		
30577	Fee: \$1,106.60	Benefit: 75% = \$829.95		
		UMOUR, exploration of pancreas or duodenum, followed by local excision of ir (Anaes.) (Assist.)		
30578	Fee: \$1,165.55	Benefit: 75% = \$874.20		
	ENDOCRINE T tumour (Anaes.)	UMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal (Assist.)		
30580	Fee: \$1,062.15	Benefit: 75% = \$796.65		
	ENDOCRINE T (Assist.)	UMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.)		
30581	Fee: \$774.55	Benefit: 75% = \$580.95		
	DISTAL PANC	REATECTOMY (Anaes.) (Assist.)		
30583	Fee: \$1,213.35	Benefit: 75% = \$910.05		
30584		D-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of		

T8. SUF	URGICAL OPERATIONS 1. GENE			
	Fee: \$1,790.95	Benefit: 75% = \$1343.25		
	PANCREATIC C means (Anaes.) (A	YST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic Assist.)		
30586	Fee: \$712.50	Benefit: 75% = \$534.40		
	PANCREATIC C	YST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.)		
30587	Fee: \$737.65	Benefit: 75% = \$553.25		
	PANCREATICO	-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.)		
30589	Fee: \$1,271.10	Benefit: 75% = \$953.35		
	PANCREATICO	-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.)		
30590	Fee: \$1,401.55	Benefit: 75% = \$1051.20		
	PANCREATECT (Assist.)	OMY, near total or total (including duodenum), with or without splenectomy (Anaes.)		
30593	Fee: \$1,917.95	Benefit: 75% = \$1438.50 85% = \$1833.25		
	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.)			
30594	Fee: \$2,213.10	Benefit: 75% = \$1659.85		
	SPLENORRHAP	HY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.)		
30596	Fee: \$911.65	Benefit: 75% = \$683.75		
	SPLENECTOMY	' (Anaes.) (Assist.)		
30597	Fee: \$731.70	Benefit: 75% = \$548.80		
	SPLENECTOMY incision (Anaes.)	7, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal (Assist.)		
30599	Fee: \$1,327.80	Benefit: 75% = \$995.85		
	DIAPHRAGMAT	FIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.)		
30600	Fee: \$789.55	Benefit: 75% = \$592.20		
	1 0	rnia, congential repair of, by thoracic or abdominal approach, not being a service to as 31569 to 31581 apply, on a person 10 years of age or over (Anaes.) (Assist.)		
30601	Fee: \$972.60	Benefit: 75% = \$729.45		
	PORTAL HYPE	RTENSION, porto-caval shunt for (Anaes.) (Assist.)		
30602	Fee: \$1,578.55	Benefit: 75% = \$1183.95		
	PORTAL HYPE	RTENSION, meso-caval shunt for (Anaes.) (Assist.)		
30603	Fee: \$1,667.15	Benefit: 75% = \$1250.40 85% = \$1582.45		
	PORTAL HYPE	RTENSION, selective spleno-renal shunt for (Anaes.) (Assist.)		
30605	Fee: \$1,895.80	Benefit: 75% = \$1421.85		
30606		RTENSION, oesophageal transection via stapler or oversew of gastric varices with or		

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	without devascularisation (Anaes.) (Assist.)
	Fee: \$1,128.55 Benefit: 75% = \$846.45
	SMALL INTESTINE, resection of, with anastomosis, on a person under 10 years of age (Anaes.) (Assist.)
30608	Fee: \$1,278.35 Benefit: 75% = \$958.80
	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30614 applies (Anaes.) (Assist.)
30609	Fee: \$471.95 Benefit: 75% = \$354.00
	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata - removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person under 10 years of age , not being a service to which another item in this Group applies (Anaes.) (Assist.)
30611	Fee: \$572.35 Benefit: 75% = \$429.30 85% = \$487.65
	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies, on a person 10 years of age or over (Anaes.) (Assist.)
30614	Fee: \$471.95 Benefit: 75% = \$354.00
	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection, on a person 10 years of age or over (Anaes.) (Assist.)
30615	Fee: \$529.60 Benefit: 75% = \$397.20
	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a person under 10 years of age (Anaes.) (Assist.)
30618	(See para TN.8.24 of explanatory notes to this Category)Fee: $$530.60$ Benefit: $75\% = 397.95 $85\% = 451.05
	LAPAROSCOPIC SPLENECTOMY, on a person under 10 years of age (Anaes.) (Assist.)
30619	Fee: \$951.25 Benefit: 75% = \$713.45
	Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or other formal repair of in a person 10 years of age or over, other than a service to which item 30403 or 30405 applies (Anaes.) (Assist.)
30621	Fee: \$414.00 Benefit: 75% = \$310.50
	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty or Drainage of pancreas on a person under 10 years of age (Anaes.) (Assist.)
30622	(See para TN.8.14 of explanatory notes to this Category) Fee: \$688.50 Benefit: 75% = \$516.40
	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) on a person under 10 years of age (Anaes.) (Assist.)
30623	Fee: \$688.50 Benefit: 75% = \$516.40
30626	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person under 10

T8. SUF	RGICAL OPERAT	IONS 1. GENERAL	
	years of age (An	aes.) (Assist.)	
	Fee: \$691.70	Benefit: 75% = \$518.80	
		Y, diagnostic, not being a service associated with any other laparoscopic procedure, on a years of age (Anaes.)	
30627	(See para TN.8.15 Fee: \$290.55	of explanatory notes to this Category) Benefit: 75% = \$217.95	
	HYDROCELE,	tapping of	
30628	Fee: \$36.15	Benefit: 75% = \$27.15 85% = \$30.75	
	Hydrocele, remo 30644 applies (A	oval of, other than a service associated with a service to which item 30641, 30642 or Anaes.)	
30631	Fee: \$240.45	Benefit: 75% = \$180.35 85% = \$204.40	
		ical correction of, other than a service associated with a service to which item 30641, applies—one procedure (Anaes.) (Assist.)	
30635	Fee: \$296.45	Benefit: 75% = \$222.35	
	GASTROSTOMY BUTTON, caecostomy antegrade enema device (chait etc) and/or stomal indwelling device, non-endoscopic insertion of, or non-endoscopic replacement of, on a person under 10 years of age (Anaes.)		
30636	Fee: \$236.90	Benefit: 75% = \$177.70 85% = \$201.40	
	ENTEROSTOM years of age (An	Y or COLOSTOMY, closure of not involving resection of bowel, on a person under 10 aes.) (Assist.)	
30637	Fee: \$785.90	Benefit: 75% = \$589.45	
	COLOSTOMY	OR ILEOSTOMY, refashioning of, on a person under 10 years of age (Anaes.) (Assist.)	
30639	Fee: \$785.90	Benefit: 75% = \$589.45 85% = \$701.20	
		and irreducible scrotal hernia, where duration of surgery exceeds 2 hours, in a person 10 over, other than a service to which item 30403, 30405, 30614, 30615 or 30621 applies .)	
30640	Fee: \$929.60	Benefit: 75% = \$697.20	
	ORCHIDECTOR (Anaes.) (Assist.	MY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis	
30641	Fee: \$414.00	Benefit: 75% = \$310.50	
		adical, unilateral, with or without insertion of testicular prosthesis, other than a service a service to which item 30631, 30635, 30641, 30643 or 30644 applies (Anaes.) (Assist.)	
30642	Fee: \$529.60	Benefit: 75% = \$397.20	
		N OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and excision of spermatic cord and testis on a person under 10 years of age (Anaes.) (Assist.)	
30643	Fee: \$688.50	Benefit: 75% = \$516.40	
30644		N OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and excision of spermatic cord and testis on a person 10 years of age or over (Anaes.)	

T8. SUF	RGICAL OPERAT	IONS 1. GENERAL
	(Assist.)	
	Fee: \$529.60	Benefit: 75% = \$397.20
	APPENDICECT age (Anaes.) (As	OMY, not being a service to which item 30574 applies, on a person under 10 years of sist.)
30645	Fee: \$588.25	Benefit: 75% = \$441.20
	LAPAROSCOP	IC APPENDICECTOMY, on a person under 10 years of age (Anaes.) (Assist.)
30646	Fee: \$588.25	Benefit: 75% = \$441.20
	HAEMORRHAG years of age (An	GE, arrest of, following circumcision requiring general anaesthesia on a person under 10 aes.)
30649	Fee: \$190.65	Benefit: 75% = \$143.00 85% = \$162.10
	Circumcision of	the penis (other than a service to which item 30658 applies)
30654	Fee: \$47.25	Benefit: 75% = \$35.45 85% = \$40.20
	Circumcision of or Group T10 ap	the penis, when performed in conjunction with a service to which an item in Group T7 plies (Anaes.)
30658	Fee: \$144.25	Benefit: 75% = \$108.20 85% = \$122.65
	HAEMORRHAO of age or over (A	GE, arrest of, following circumcision requiring general anaesthesia on a person 10 years anaes.)
30663	Fee: \$146.65	Benefit: 75% = \$110.00 85% = \$124.70
		S or PHIMOSIS, reduction of, under general anaesthesia, with or without dorsal ag a service associated with a service to which another item in this Group applies
30666	Fee: \$48.20	Benefit: 75% = \$36.15 85% = \$41.00
	COCCYX, excis	ion of (Anaes.) (Assist.)
30672	Fee: \$452.55	Benefit: 75% = \$339.45
	PILONIDAL SI	NUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.)
30676	Fee: \$385.10	Benefit: 75% = \$288.85 85% = \$327.35
	PILONIDAL SI	NUS, injection of sclerosant fluid under anaesthesia (Anaes.)
30679	Fee: \$97.85	Benefit: 75% = \$73.40 85% = \$83.20
	WITHOUT intra	opy, examination of the small bowel (oral approach), with or without biopsy, procedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not th another item in this subgroup (with the exception of item 30682 or 30686)
	The patient to w	nom the service is provided must:
	(i) have recurre	ent or persistent bleeding; and
30680	(ii) be anaemic	or have active bleeding; and

T8. SU	GICAL OPERATIONS 1. GENERATIONS
	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identi the cause of the bleeding. (Anaes.)
	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,188.70 Benefit: 75% = \$891.55 85% = \$1104.00
	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, no 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 identi the cause of the bleeding.
	(Anaes.)
30682	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,188.70 Benefit: 75% = \$891.55 85% = \$1104.00
	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686)
	The patient to whom the service is provided must:
	(i) have recurrent or persistent bleeding; and
	(ii) be anaemic or have active bleeding; and
	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identi the cause of the bleeding.
	(Anaes.)
30684	(See para TN.8.17 of explanatory notes to this Category) Fee: $$1,462.90$ Benefit: $75\% = 1097.20 $85\% = 1378.20
	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684)
30686	The patient to whom the service is provided must:

T8. SUR	GICAL OPERATIONS 1. GENERAL
	(i) have recurrent or persistent bleeding; and
	(ii) be anaemic or have active bleeding; and
	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)
	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,462.90 Benefit: 75% = \$1097.20 85% = \$1378.20
	ENDOSCOPY with RADIOFREQUENCY ABLATION of mucosal metaplasia for the treatment of Barrett's Oesophagus in a single course of treatment, following diagnosis of high grade dysplasia confirmed by histological examination (Anaes.)
30687	(See para TN.8.17, TN.8.20 of explanatory notes to this Category) Fee: \$483.70 Benefit: 75% = \$362.80 85% = \$411.15
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30688	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$370.75 Benefit: 75% = \$278.10 85% = \$315.15
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30690	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$572.30 Benefit: 75% = \$429.25 85% = \$487.60
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30692	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$370.75 Benefit: 75% = \$278.10 85% = \$315.15
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30694	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$572.30 Benefit: 75% = \$429.25 85% = \$487.60
	ENDOSCOPIC ULTRASOUND GUIDED FINE NEEDLE ASPIRATION BIOPSY(S) (endoscopy with ultrasound imaging) to obtain one or more specimens from either:
	(a) mediastinal mass(es) or
	(b) locoregional nodes to stage non-small cell lung carcinoma
30696	

T8. SUI	RGICAL OPERATIONS	1. GENERAL
	not being a service associated with another item in this subgroup or to which items 30 apply (Anaes.)	710 and 55054
	(See para TN.8.21 of explanatory notes to this Category) Fee: \$572.30 Benefit: 75% = \$429.25 85% = \$487.60	
	ENDOBRONCHIAL ULTRASOUND GUIDED BIOPSY(S) (bronchoscopy with ult with or without associated fluoroscopic imaging) to obtain one or more specimens by	0 0
	(a) transbronchial biopsy(s) of peripheral lung lesions; or	
	(b) fine needle aspiration(s) of a mediastinal mass(es); or	
	(c) fine needle aspiration(s) of locoregional nodes to stage non-small cell lung carcino	oma
	not being a service associated with another item in this subgroup or to which items 30 41898, and 60500 to 60509 applies (Anaes.)	696, 41892,
30710	(See para TN.8.21 of explanatory notes to this Category) Fee: \$572.30 Benefit: 75% = \$429.25 85% = \$487.60	
	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (be utilising horizontal frozen sections with mapping of all excised tissue, and histologica all excised tissue by the specialist performing the procedure, if the specialist is recogn Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer se	l examination of nised by the
31000	(See para TN.8.151 of explanatory notes to this Category) Fee: \$590.20 Benefit: 75% = \$442.65 85% = \$505.50	
	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (be utilising horizontal frozen sections with mapping of all excised tissue, and histologica all excised tissue by the specialist performing the procedure, if the specialist is recogr Australasian College of Dermatologists as an approved Mohs surgeon—7 to 12 section (Anaes.)	l examination of hised by the
31001	(See para TN.8.151 of explanatory notes to this Category) Fee: \$737.65 Benefit: 75% = \$553.25 85% = \$652.95	
	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (be utilising horizontal frozen sections with mapping of all excised tissue, and histologica all excised tissue by the specialist performing the procedure, if the specialist is recogn Australasian College of Dermatologists as an approved Mohs surgeon—13 or more se	l examination of ised by the
31002	(See para TN.8.151 of explanatory notes to this Category) Fee: \$885.25 Benefit: 75% = \$663.95 85% = \$800.55	
	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all histological examination of all excised tissue by the specialist performing the procedu is recognised by the Australasian College of Dermatologists as an approved Mohs sur sections	re, if the specialist
	Not applicable to a service performed in association with a service to which item 310	00 applies (Anaes.)
31003	(See para TN.8.151 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERATIO	DNS	1. GENERAL
	Fee: \$590.20	Benefit: 75% = \$442.65 85% = \$505.50	
	histological examin	cin tumour utilising horizontal frozen sections with magnation of all excised tissue by the specialist performing e Australasian College of Dermatologists as an approv)	the procedure, if the specialist
	Not applicable to a	service performed in association with a service to whi	ch item 31001 applies (Anaes.)
31004	(See para TN.8.151 o Fee: \$737.65	of explanatory notes to this Category) Benefit: 75% = \$553.25 85% = \$652.95	
	histological examin	kin tumour utilising horizontal frozen sections with magnation of all excised tissue by the specialist performing e Australasian College of Dermatologists as an approv	the procedure, if the specialist
	Not applicable to a	service performed in association with a service to whi	ich item 31002 applies (Anaes.)
31005	(See para TN.8.151 o Fee: \$885.25	of explanatory notes to this Category) Benefit: 75% = \$663.95 85% = \$800.55	
	Tumour, cyst, ulce removal of and sut	r or scar (other than a scar removed during the surgical ure, if:	l approach at an operation),
	(a) the lesion size	e is not more than 10 mm in diameter; and	
	(b) the removal	is from a mucous membrane by surgical excision (othe	r than by shave excision); and
	(c) the specimen	excised is sent for histological examination (Anaes.)	
31206	Fee: \$97.00	Benefit: 75% = \$72.75 85% = \$82.45	
	Tumour, cyst, ulce removal of and sut	r or scar (other than a scar removed during the surgical ure, if:	approach at an operation),
	(a) the lesion siz	e is more than 10 mm, but not more than 20 mm, in dia	ameter; and
	(b) the removal	is from a mucous membrane by surgical excision (othe	r than by shave excision); and
	(c) the specimen	excised is sent for histological examination (Anaes.)	
31211	Fee: \$125.05	Benefit: 75% = \$93.80 85% = \$106.30	
	Tumour, cyst, ulce removal of and sut	r or scar (other than a scar removed during the surgical ure, if:	l approach at an operation),
	(a) the lesion siz	e is more than 20 mm in diameter; and	
	(b) the removal	is from a mucous membrane by surgical excision (othe	er than by shave excision); and
	(c) the specimen	excised is sent for histological examination (Anaes.)	
31216	Fee: \$145.85	Benefit: 75% = \$109.40 85% = \$124.00	
31220	-	an viral verrucae (common warts) and seborrheic kerate emoved during the surgical approach at an operation), r	· · · · ·

T8. SUF	RGICAL OPERATIONS 1. GENERA
	(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
	(c) all of the specimens excised are sent for histological examination (Anaes.)
	Fee: \$218.00 Benefit: 75% = \$163.50 85% = \$185.30
	Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions, if:
	(a) the size of each lesion is not more than 10 mm in diameter; and
	(b) each removal is from a mucous membrane by surgical excision (other than by shave excision); an
	(c) each site of excision is closed by suture; and
	(d) all of the specimens excised are sent for histological examination (Anaes.)
31221	Fee: \$218.00 Benefit: 75% = \$163.50 85% = \$185.30
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if:
	(a) the size of each lesion is not more than 10 mm in diameter; and
	(b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical 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.)
31225	Fee: \$387.40 Benefit: 75% = \$290.55 85% = \$329.30
	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HIDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes.)
31245	(See para TN.8.23 of explanatory notes to this Category)Fee: $$374.90$ Benefit: $75\% = 281.20 $85\% = 318.70
	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface when the specimen excised is sent for histological confirmation of diagnosis (Anaes.)
31250	Fee: \$374.90 Benefit: 75% = \$281.20 85% = \$318.70
	Muscle, bone or cartilage, excision of one or more of, if clinically indicated, and if:
	(a) the specimen excised is sent for histological confirmation; and
	(b) a malignant tumour of skin covered by item 31000, 31001, 31002, 31003, 31004, 31005, 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371, 31372, 31373, 31374, 31375 or 31376 is excised (Anaes.)
31340	

T8. SUF	GICAL OPERATIONS 1. GENERAL
	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.)
31345	Fee: \$214.35 Benefit: 75% = \$160.80 85% = \$182.20
	Liposuction (suction assisted lipolysis) to one regional area for contour problems of abdominal, upper arm or thigh fat because of repeated insulin injections, if:
	(a) the lesion is subcutaneous; and
	(b) the lesion is 50 mm or more in diameter; and
	(c) photographic and/or diagnostic imaging evidence demonstrating the need for this service is documented in the patient notes (Anaes.)
31346	(See para TN.8.101 of explanatory notes to this Category) Fee: \$214.35 Benefit: 75% = \$160.80 85% = \$182.20
	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person 10 years of age or over, not being a service to which another item in this Group applies (Anaes.) (Assist.)
31350	Fee: \$440.30 Benefit: 75% = \$330.25 85% = \$374.30
	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of by surgical excision, where <i>histological proof of malignancy has been obtained</i> , not being a service to which another item in this Group applies (Anaes.) (Assist.)
31355	Fee: \$725.90 Benefit: 75% = \$544.45 85% = \$641.20
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and
	(b) the necessary excision diameter is less than 6 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy;
	not in association with item 45201 (Anaes.)
31356	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$224.90 Benefit: 75% = \$168.70 85% = \$191.20
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and
31357	(b) the necessary excision diameter is less than 6 mm; and

T8. SUF	GICAL OPERATIONS	1. GENERAL
	(c) the excised specimen is sent for histological examination;	
	not in association with item 45201 (Anaes.)	
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$111.45 Benefit: 75% = \$83.60 85% = \$94.75	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	372, 31373, 31374,
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or f 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 (Anae	s.)
31358	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$275.20 Benefit: 75% = \$206.40 85% = \$233.95	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31 31375 or 31376), surgical excision (other than by shave excision), if:	372, 31373, 31374,
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia (the	applicable site); and
	(b) the necessary excision area is at least one third of the surface area of the applic	cable site; and
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy	
	(H) (Anaes.)	
31359	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$335.45 Benefit: 75% = \$251.60	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheid including a cyst, ulcer or scar (other than a scar removed during the surgical approac surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or f area; and	from a contiguous
	(b) the necessary excision diameter is 6 mm or more; and	
	(c) the excised specimen is sent for histological examination (Anaes.)	
31360	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$170.75 Benefit: 75% = \$128.10 85% = \$145.15	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	372, 31373, 31374,
31361	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lowe including, the	r limb (distal to, and

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and
	(b) the necessary excision diameter is less than 14 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy;
	not in association with item 45201 (Anaes.)
	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$189.70 Benefit: 75% = \$142.30 85% = \$161.25
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and
	(b) the necessary excision diameter is less than 14 mm; and
	(c) the excised specimen is sent for histological examination;
	not in association with item 45201 (Anaes.)
31362	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$136.05 Benefit: 75% = \$102.05 85% = \$115.65
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and
	(b) the necessary excision diameter is 14 mm or more; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)
31363	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$248.20 Benefit: 75% = \$186.15 85% = \$211.00
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and
31364	(b) the necessary excision diameter is 14 mm or more; and

T8. SUF	GICAL OPERATIONS	1. GENERAL
	(c) the excised specimen is sent for histological examination (Anaes.)	
	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$170.75 Benefit: 75% = \$128.10 85% = \$145.15	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 313' or 31373), surgical excision (other than by shave excision) and repair of, if:	70, 31371, 31372
	(a) the lesion is excised from any part of the body not covered by item 31356, 3135 31363; and	8, 31359, 31361 or
	(b) the necessary excision diameter is less than 15 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31365	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$160.85 Benefit: 75% = \$120.65 85% = \$136.75	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic lincluding a cyst, ulcer or scar (other than a scar removed during the surgical approach surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from any part of the body not covered by item 31357, 3136 and	0, 31362 or 31364;
	(b) the necessary excision diameter is less than 15 mm; and	
	(c) the excised specimen is sent for histological examination;	
	not in association with item 45201 (Anaes.)	
31366	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$97.00 Benefit: 75% = \$72.75 85% = \$82.45	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 313' 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	72, 31373, 31374,
	(a) the lesion is excised from any part of the body not covered by item 31356, 3135 31363; and	8, 31359, 31361 or
	(b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and	l
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31367	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$217.00 Benefit: 75% = \$162.75 85% = \$184.45	
31368	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic lincluding 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:	

T8. SUR	GICAL OPERATIONS 1. GENERAL
	(a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and
	(b) the necessary excision diameter is 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.)
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$127.55 Benefit: 75% = \$95.70 85% = \$108.45
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and
	(b) the necessary excision diameter is more than 30 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)
31369	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$249.85 Benefit: 75% = \$187.40 85% = \$212.40
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and
	(b) the necessary excision diameter is more than 30 mm; and
	(c) the excised specimen is sent for histological examination (Anaes.)
31370	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$145.85 Benefit: 75% = \$109.40 85% = \$124.00
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:
	(a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and
	(b) the necessary excision diameter is 6 mm or more; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)
31371	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$362.70 Benefit: 75% = \$272.05 85% = \$308.30
31372	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:

T8. SUR	GICAL OPERATIONS	1. GENERAL		
	(a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower and including,	limb (distal to,		
	the knee) or distal upper limb (distal to, and including, the ulnar styloid); and			
	(b) the necessary excision diameter is less than 14 mm; and			
	(c) the excised specimen is sent for histological examination; and			
	(d) malignancy is confirmed from the excised specimen or previous biopsy;			
	not in association with item 45201 (Anaes.)			
	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$313.65 Benefit: 75% = \$235.25 85% = \$266.65			
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of si carcinoma of skin, definitive surgical excision (other than by shave excision) and repair			
	(a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower and including,	limb (distal to,		
	the knee) or distal upper limb (distal to, and including, the ulnar styloid); and			
	(b) the necessary excision diameter is 14 mm or more; and			
	(c) the excised specimen is sent for histological examination; and			
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)			
31373	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$362.50 Benefit: 75% = \$271.90 85% = \$308.15			
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of si carcinoma of skin, definitive surgical excision (other than by shave excision) and repair			
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372	2 or 31373; and		
	(b) the necessary excision diameter is less than 15 mm; and			
	(c) the excised specimen is sent for histological examination; and			
	(d) malignancy is confirmed from the excised specimen or previous biopsy;			
	not in association with item 45201 (Anaes.)			
31374	(See para TN.8.125, TN.1.21 of explanatory notes to this Category) Fee: \$286.40 Benefit: 75% = \$214.80 85% = \$243.45			
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of si carcinoma of skin, definitive surgical excision (other than by shave excision) and repair			
	(a) the tumour is excised from any part of the body not covered by item 31371, 3137	2 or 31373; and		
	(b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and			
31375	(c) the excised specimen is sent for histological examination; and			

T8. SUF	RGICAL OPERATIONS 1. GENE	RAL
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$308.25 Benefit: 75% = \$231.20 85% = \$262.05	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:	l cell
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; a	nd
	(b) the necessary excision diameter is more than 30 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
31376	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$357.25 Benefit: 75% = \$267.95 85% = \$303.70	
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diame (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	ter
31400	Fee: \$265.25 Benefit: 75% = \$198.95 85% = \$225.50	
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and including 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmat of malignancy has been obtained (Anaes.) (Assist.)	ion
31403	Fee: \$306.15 Benefit: 75% = \$229.65	
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	
31406	Fee: \$510.20 Benefit: 75% = \$382.65 85% = \$433.70	
	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)	
31409	Fee: \$1,585.10 Benefit: 75% = \$1188.85	
	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical appro (Anaes.) (Assist.)	bach
31412	Fee: \$1,952.50 Benefit: 75% = \$1464.40	
	LYMPH NODE OF NECK, biopsy of (Anaes.)	
31420	Fee: \$186.85 Benefit: 75% = \$140.15 85% = \$158.85	
	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of tissue and lymph nodes from one side of the neck, on a person 10 years of age or over (Anaes.) (Ass	
31423	(See para TN.8.24 of explanatory notes to this Category) Fee: \$408.20 Benefit: 75% = \$306.15 85% = \$347.00	
	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.)	

T8. SUF	GICAL OPERATIONS	1. GENERAL
	Fee: \$816.30 Benefit: 75% = \$612.25	
	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on preservation of one or more of: internal jugular vein, sternocleido-mastoid m nerve (Anaes.) (Assist.)	
31429	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,272.15 Benefit: 75% = \$954.15	
	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and dissections) (Anaes.) (Assist.)	III (bilateral supraomohyoid
31432	(See para TN.8.24 of explanatory notes to this Category)Fee: $$1,360.60$ Benefit: $75\% = 1020.45	
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node neck (Anaes.) (Assist.)	levels on one side of the
31435	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,000.05 Benefit: 75% = \$750.05	
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node neck with preservation of one or more of: internal jugular vein, sternocleido- accessory nerve (Anaes.) (Assist.)	
31438	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,585.10 Benefit: 75% = \$1188.85	
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedu hour or less (Anaes.) (Assist.)	re, where the time taken is 1
31450	Fee: \$413.15 Benefit: 75% = \$309.90	
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedu more than 1 hour (Anaes.) (Assist.)	re, where the time taken in
31452	Fee: \$722.90 Benefit: 75% = \$542.20	
	LAPAROSCOPY with drainage of pus, bile or blood, as an independent pro-	cedure (Anaes.) (Assist.)
31454	Fee: \$572.30 Benefit: 75% = \$429.25	
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, w feeding tube has failed or is inappropriate due to the patient's medical condition	
31456	Fee: \$249.50 Benefit: 75% = \$187.15	
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, w feeding tube has failed or is inappropriate due to the patient's medical conditi imaging intensification is clinically indicated (Anaes.)	
31458	Fee: \$299.35 Benefit: 75% = \$224.55	
	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, includin services (Anaes.) (Assist.)	g any associated imaging
31460	Fee: \$362.70 Benefit: 75% = \$272.05	
	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with m resection (Anaes.) (Assist.)	ajor upper gastro-intestinal

T8. SUF	GICAL OPERATI	IONS	1. GENERAL
	without closure o	OPERATION BY FUNDOPLASTY, via abdominal or thora of the diaphragmatic hiatus, by laparoscopic technique - not es (Anaes.) (Assist.)	
31464	(See para TN.8.19 Fee: \$885.25	of explanatory notes to this Category) Benefit: 75% = \$663.95	
		OPERATION BY FUNDOPLASTY, via abdominal or thora of the diaphragmatic hiatus, revision procedure, by laparosco)	
31466	(See para TN.8.19 Fee: \$1,327.85	of explanatory notes to this Category) Benefit: 75% = \$995.90	
		AGEAL HIATUS HERNIA, repair of, with complete reduct hiatus, with or without fundoplication (Anaes.) (Assist.)	ction of hernia, resection of
31468	Fee: \$1,458.80	Benefit: 75% = \$1094.10	
	LAPAROSCOPI	C SPLENECTOMY, on a person 10 years of age or over (A	Anaes.) (Assist.)
31470	Fee: \$731.70	Benefit: 75% = \$548.80	
	CHOLECYSTOI CHOLEDOCHO	DUODENOSTOMY, CHOLECYSTOENTEROSTOMY, DEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure ned (Anaes.) (Assist.)	where prior biliary surgery
31472	Fee: \$1,188.50	Benefit: 75% = \$891.40	
	BREAST, BENI	GN LESION up to and including 50mm in diameter, includi fibrocystic disease, open surgical biopsy or excision of, wit	
31500	(See para TN.8.25 Fee: \$264.20	of explanatory notes to this Category) Benefit: 75% = \$198.15 85% = \$224.60	
	BREAST, BENI	GN LESION more than 50mm in diameter, excision of (Ana	aes.) (Assist.)
31503	(See para TN.8.25 Fee: \$352.30	of explanatory notes to this Category) Benefit: 75% = \$264.25 85% = \$299.50	
		DRMALITY detected by mammography or ultrasound wher edure is performed, excision biopsy of (Anaes.) (Assist.)	re guidewire or other
31506	(See para TN.8.25 Fee: \$396.35	of explanatory notes to this Category) Benefit: 75% = \$297.30	
51500		GNANT TUMOUR, open surgical biopsy of, with or witho	out frozen section histology
31509	(See para TN.8.25 Fee: \$352.30	of explanatory notes to this Category) Benefit: 75% = \$264.25 85% = \$299.50	
	BREAST, MALI histology (Anaes	GNANT TUMOUR, complete local excision of, with or wi .) (Assist.)	thout frozen section
31512	Fee: \$660.55	Benefit: 75% = \$495.45	
	BREAST, TUMO tumour (Anaes.)	OUR SITE, re-excision of following open biopsy or incomp (Assist.)	lete excision of malignant
		of explanatory notes to this Category)	

T8. SUF	RGICAL OPERAT	IONS	1. GENERAL	
	Fee: \$443.15	Benefit: 75% = \$332.40		
	histology when ta	GNANT TUMOUR, complete local excision of, with or without argeted intraoperative radiotherapy (using an Intrabeam® device he requirements of item 15900 are met for the patient (Anaes.) (A) is performed	
31516	Fee: \$880.85	Benefit: 75% = \$660.65		
	BREAST, total n	hastectomy (H) (Anaes.) (Assist.)		
31519	Fee: \$747.85	Benefit: 75% = \$560.90		
	BREAST, subcut	taneous mastectomy (H) (Anaes.) (Assist.)		
31524	Fee: \$1,056.90	Benefit: 75% = \$792.70		
		ctomy for gynecomastia, with or without liposuction (suction ass ssociated with a service to which item 45585 applies (H) (Anaes		
31525	Fee: \$528.30	Benefit: 75% = \$396.25		
		SY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assi ging guidance, for histological examination, where imaging has		
	(a) microcalcif	cation of lesion; or		
	(b) impalpable	lesion less than 1cm in diameter		
	- including pre- 31539, 31545 or	operative localisation of lesion where performed, not being a ser 31548 apply	rvice to which items	
31530	Fee: \$605.20	Benefit: 75% = \$453.90 85% = \$520.50		
		ASPIRATION of an impalpable breast lesion detected by mamm but not including imaging (Anaes.)	ography or ultrasound,	
31533	(See para TN.8.26 Fee: \$140.10	of explanatory notes to this Category) Benefit: 75% = \$105.10 85% = \$119.10		
		erative localisation of lesion of, by hookwire or similar device, uses - but not including imaging, not being a service to which item naes.)		
31536	Fee: \$192.45	Benefit: 75% = \$144.35 85% = \$163.60		
	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which item 31530, 31536 or 31548 applies (Anaes.)			
31539	(See para TN.8.27 Fee: \$405.20	of explanatory notes to this Category) Benefit: 75% = \$303.90		
	radiologist as det interventional im	guidewire localisation of lesion, by hookwire or similar device, ermined by the Royal Australian and New Zealand College of R aging techniques prior to using a bore-enbloc stereotactic biopsy ce associated with a service to which item 31536 applies (Anaes.	adiologists, using - including imaging	
31542	(See para TN.8.28 Fee: \$200.10	of explanatory notes to this Category) Benefit: 75% = \$150.10 85% = \$170.10		
31545	BREAST, BIOPS	SY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc	stereotactic biopsy, for	

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	histological examination, when conducted by a surgeon as determined by the Royal of Surgeons; where imaging has demonstrated an impalpable lesion of less than 15m including initial guidewire localisation of lesion, by hookwire or similar device, usin imaging techniques and including imaging not being a service associated with a serv 31530, 31536 or 31548 applies (Anaes.)	in diameter, g interventional
	(See para TN.8.27 of explanatory notes to this Category) Fee: \$605.20 Benefit: 75% = \$453.90 85% = \$520.50	
	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using mechanical biops histological examination, not being a service to which items 31530, 31539 or 31545	
31548	Fee: \$140.10 Benefit: 75% = \$105.10 85% = \$119.10	
	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION inclu granulomatous mastitis or similar, exploration and drainage of when undertaken in the of a hospital, excluding aftercare (Anaes.)	
31551	Fee: \$220.20 Benefit: 75% = \$165.15	
	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.)	
31554	Fee: \$440.45 Benefit: 75% = \$330.35	
	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.)	
31557	Fee: \$352.30 Benefit: 75% = \$264.25 85% = \$299.50	
	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.)	
31560	Fee: \$352.30 Benefit: 75% = \$264.25 85% = \$299.50 Extended Medicare Safety Net Cap: \$281.85	
	INVERTED NIPPLE, surgical eversion of (Anaes.)	
31563	Fee: \$263.90 Benefit: 75% = \$197.95 85% = \$224.35	
	ACCESSORY NIPPLE, excision of (Anaes.)	
31566	Fee: \$132.05 Benefit: 75% = \$99.05 85% = \$112.25	
	BARIATRIC	
	Adjustable gastric band, placement of, with or without crural repair taking 45 minute patient with clinically severe obesity (Anaes.) (Assist.)	es or less, for a
31569	(See para TN.8.29 of explanatory notes to this Category)Fee: $\$863.15$ Benefit: $75\% = \$647.40$	
	Gastric bypass by Roux-en-Y including associated anastomoses, with or without crural repair taking 4 minutes or less, for a patient with clinically severe obesity not being associated with a service to whic item 30515 applies (Anaes.) (Assist.)	
31572	(See para TN.8.29 of explanatory notes to this Category) Fee: \$1,062.15 Benefit: 75% = \$796.65	
	Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a pat severe obesity (Anaes.) (Assist.)	ient with clinically
31575	(See para TN.8.29 of explanatory notes to this Category) Fee: \$863.15 Benefit: 75% = \$647.40	
31578	Gastroplasty (excluding by gastric plication), with or without crural repair taking 45	minutes or less, for

RGICAL OPERATIONS	1. GENERAL		
a patient with clinically severe obesity (Anaes.) (Assist.)			
(See para TN.8.29 of explanatory notes to this Category) Fee: \$863.15 Benefit: 75% = \$647.40			
Gastric bypass by biliopancreatic diversion with or without duodenal switch including gastric resection and anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)			
(See para TN.8.29 of explanatory notes to this Category) Fee: \$1,062.15 Benefit: 75% = \$796.65			
Surgical reversal of adjustable gastric banding (removal or replacement of gas gastroplasty (excluding by gastric plication) or biliopancreatic diversion being 31569 to 31581 apply (Anaes.) (Assist.)			
(See para TN.8.30 of explanatory notes to this Category) Fee: \$1 563 75 Benefit: 75% = \$1172 85			
Adjustment of gastric band as an independent procedure including any associa	ited consultation		
Fee: \$99.50 Benefit: 75% = \$74.65 85% = \$84.60			
Adjustment of gastric band reservoir, repair, revision or replacement of (Anae	s.) (Assist.)		
Fee: \$255.75 Benefit: 75% = \$191.85 85% = \$217.40			
	2. COLORECTAL		
Group T8. Surgical Operations			
Subgroup 2. Colorectal			
LARGE INTESTINE, resection of, without anastomosis, including right hemi formation of stoma) (Anaes.) (Assist.)	colectomy (including		
Fee: \$1,047.85 Benefit: 75% = \$785.90			
LARGE INTESTINE, resection of, with anastomosis, including right hemicol	ectomy (Anaes.) (Assist.)		
Fee: \$1,096.05 Benefit: 75% = \$822.05			
LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse without anastomosis, not being a service associated with a service to which ite 32006 applies (Anaes.) (Assist.)			
Fee: \$1,168.75 Benefit: 75% = \$876.60			
LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse with anastomosis, not being a service associated with a service to which item 32006 applies (Anaes.) (Assist.)			
Fee: \$1,320.35 Benefit: 75% = \$990.30			
LEFT HEMICOLECTOMY, including the descending and sigmoid colon (inc			
stoma) (Anaes.) (Assist.)	eluding formation of		
stoma) (Anaes.) (Assist.)	luding formation of		
	luding formation of		
	a patient with clinically severe obesity (Anaes.) (Assist.) (See para TN.8.29 of explanatory notes to this Category) Fee: \$863.15 Benefit: 75% = \$647.40 Gastric bypass by biliopancreatic diversion with or without duodenal switch in and anastomoses, with or without crural repair taking 45 minutes or less, for a severe obesity (Anaes.) (Assist.) (See para TN.8.29 of explanatory notes to this Category) Fee: \$1,062.15 Benefit: 75% = \$796.65 Surgical reversal of adjustable gastric banding (removal or replacement of gas gastroplasty (excluding by gastric plication) or biliopancreatic diversion being 31569 to 31581 apply (Anaes.) (Assist.) (See para TN.8.30 of explanatory notes to this Category) Fee: \$1,563.75 Benefit: 75% = \$71.65 Surgical reversal of adjustable gastric band as an independent procedure including any associa Fee: \$99.50 Benefit: 75% = \$74.65 Adjustment of gastric band reservoir, repair, revision or replacement of (Anae Fee: \$255.75 Benefit: 75% = \$191.85 8GICAL OPERATIONS Group T8. Surgical Operations Subgroup 2. Colorectal LARGE INTESTINE, resection of, without anastomosis, including right hemic formation of stoma) (Anaes.) (Assist.) Fee: \$1,047.85 Benefit: 75% = \$822.05 LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse without anastomosis, not b		

T8. SUF	GICAL OPERATIO	ONS	2. COLORECTAL
	TOTAL COLECT	OMY AND ILEORECTAL ANAS	ΓΟMOSIS (Anaes.) (Assist.)
32012	Fee: \$1,531.50	Benefit: 75% = \$1148.65	
	TOTAL COLECT (Assist.)	OMY WITH EXCISION OF RECT	'UM AND ILEOSTOMY 1 surgeon (Anaes.)
32015	Fee: \$1,882.15	Benefit: 75% = \$1411.65	
			UM AND ILEOSTOMY, COMBINED SECTION (including aftercare) (Anaes.) (Assist.)
32018	Fee: \$1,596.00	Benefit: 75% = \$1197.00	
		OMY WITH EXCISION OF RECT OPERATION; PERINEAL RESEC	UM AND ILEOSTOMY, COMBINED CTION (Assist.)
32021	Fee: \$572.30	Benefit: 75% = \$429.25	
		on of stent or stents for large bowel ny image intensification, where the	obstruction, stricture or stenosis, including obstruction is due to:
	a) a pre-diag	gnosed colorectal cancer, or cancer	of an organ adjacent to the bowel; or
	b) an unkno	wn diagnosis (Anaes.)	
32023	(See para TN.8.17 of Fee: \$564.25	explanatory notes to this Category) Benefit: 75% = \$423.20	
	ANASTOMOSIS	(of the rectum) greater than 10 centi he not being a service associated wit	ECTION WITH INTRAPERITONEAL metres from the anal verge excluding resection of h a service to which item 32103, 32104 or 32106
32024	Fee: \$1,386.45	Benefit: 75% = \$1039.85	
	ANASTOMOSIS	(of the rectum) less than 10 centime	ECTION WITH EXTRAPERITONEAL tres from the anal verge, with or without covering which item 32103, 32104 or 32106 applies
32025	Fee: \$1,854.50	Benefit: 75% = \$1390.90	
			ON, with or without covering stoma, where the or less from the anal verge (Anaes.) (Assist.)
32026	Fee: \$1,997.10	Benefit: 75% = \$1497.85	
		DR ULTRA LOW RESTORATIVE or without covering stoma (Anaes.)	RESECTION, with peranal sutured coloanal (Assist.)
32028	Fee: \$2,139.90	Benefit: 75% = \$1604.95	
		RVOIR, construction of, being a service pup applies (Anaes.) (Assist.)	vice associated with a service to which any other
32029	Fee: \$427.95	Benefit: 75% = \$321.00	
	RECTOSIGMOID	ECTOMY (Hartmann's operation)	(Anaes.) (Assist.)
32030	Fee: \$1,047.85	Benefit: 75% = \$785.90	

T8. SUF	GICAL OPERATIO	DNS	2. COLORECTAL
	RESTORATION stoma (Anaes.) (A		ilar operation, including dismantling of the
32033	Fee: \$1,531.50	Benefit: 75% = \$1148.65	
	SACROCOCCYC	EAL AND PRESACRAL TUMOUR ex	cision of (Anaes.) (Assist.)
32036	Fee: \$1,942.40	Benefit: 75% = \$1456.80	
	RECTUM AND A	ANUS, ABDOMINOPERINEAL RESEC	TION OF 1 surgeon (Anaes.) (Assist.)
32039	Fee: \$1,559.60	Benefit: 75% = \$1169.70	
		ANUS, ABDOMINOPERINEAL RESEC dominal resection (Anaes.) (Assist.)	TION OF, COMBINED SYNCHRONOUS
32042	Fee: \$1,313.85	Benefit: 75% = \$985.40	
		ANUS, ABDOMINOPERINEAL RESECT	TION OF, COMBINED SYNCHRONOUS
32045	Fee: \$491.70	Benefit: 75% = \$368.80	
		US, abdomino-perineal resection of, com e perineal surgeon also provides assistanc	
32046	Fee: \$759.85	Benefit: 75% = \$569.90	
	PERINEAL PRO	CTECTOMY (Anaes.) (Assist.)	
32047	Fee: \$885.25	Benefit: 75% = \$663.95	
		OMY with excision of rectum and ileoan without creation of temporary ileostomy	
32051	Fee: \$2,353.65	Benefit: 75% = \$1765.25	
	reservoir, with or	YOMY with excision of rectum and ileoan without creation of temporary ileostomy re) (Anaes.) (Assist.)	
32054	Fee: \$2,160.20	Benefit: 75% = \$1620.15	
		OMY with excision of rectum and ileoan surgery, perineal surgeon (Assist.)	al anastomosis with formation of ileal
32057	Fee: \$572.30	Benefit: 75% = \$429.25	
		OSURE with rectal resection and mucose reservoir, with or without temporary loop	
32060	Fee: \$2,353.65	Benefit: 75% = \$1765.25	
	formation of ileal	OSURE with rectal resection and mucose reservoir, with or without temporary loop g aftercare) (Anaes.) (Assist.)	
32063	Fee: \$2,160.20	Benefit: 75% = \$1620.15	
		OSURE with rectal resection and mucose reservoir, with or without temporary loop	
32066			

T8. SUF	RGICAL OPERAT	IONS	2. COLORECTAL
	Fee: \$572.30	Benefit: 75% = \$429.25	
	ILEOSTOMY R where appropria	• •	, including conversion of existing ileostomy
32069	Fee: \$1,741.05	Benefit: 75% = \$1305.80	
	SIGMOIDOSCO	OPIC EXAMINATION (with rigid sigme	bidoscope), with or without biopsy
32072	Fee: \$48.60	Benefit: 75% = \$36.45 85% = \$41.3	5
	ANAESTHESIA	OPIC EXAMINATION (with rigid sigmed, with or without biopsy, not being a ser op applies (Anaes.)	bidoscope), UNDER GENERAL rvice associated with a service to which another
32075	Fee: \$76.25	Benefit: 75% = \$57.20 85% = \$64.8	5
			opy up to the hepatic flexure, with or without which any of items 32222 to 32228 applies.
	(Anaes.)		
32084	(See para TN.8.17 Fee: \$113.15	, TN.8.134 of explanatory notes to this Categ Benefit: 75% = \$84.90 85% = \$96.2	
	fibreoptic colone angiodysplasia o	oscopy for the removal of 1 or more poly	exure by flexible fibreoptic sigmoidoscopy or rps or the treatment of radiation proctitis, lasma coagulation, one or more of, other than a 2222 to 32228 applies
	(Anaes.)		
32087	(See para TN.8.17 Fee: \$208.00	, TN.8.134 of explanatory notes to this Categ Benefit: 75% = \$156.00 85% = \$176	•
	ENDOSCOPIC	DILATATION OF COLORECTAL STI	RICTURES including colonoscopy (Anaes.)
22004		of explanatory notes to this Category) Benefit: 75% = \$420.55	
32094 Fee: \$560.70 Benefit: 75% = \$420.55 ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endosc or without biopsies (Anaes.)		with flexible endoscope passed by stoma, with	
32095	(See para TN.8.17 Fee: \$129.85	of explanatory notes to this Category) Benefit: 75% = \$97.40 85% = \$110.	40
	RECTAL BIOPS		esia, or under epidural or spinal (intrathecal)
32096	Fee: \$261.05	Benefit: 75% = \$195.80	
	RECTAL TUM (Assist.)	DUR of 5 centimetres or less in diameter	, per anal submucosal excision of (Anaes.)
32099	Fee: \$338.55	Benefit: 75% = \$253.95	
32102	RECTAL TUM	OUR of greater than 5 centimetres in dia	meter, indicated by pathological examination,

T8. SUF	RGICAL OPERAT	IONS	2. COLORECTAL
	per anal submuce	osal excision of (Anaes.) (Assist.)	
	Fee: \$644.85	Benefit: 75% = \$483.65	
	either 3 dimension during colonosco	DUR, of less than 4 cm in diameter, per anal excional or 2 dimensional optic viewing systems, if ropy or by local excision, other than a service associated or 32106 applies (Anaes.) (Assist.)	emoval is unable to be performed
32103	(See para TN.8.31, Fee: \$784.65	TN.8.17 of explanatory notes to this Category) Benefit: 75% = \$588.50	
	incorporating eith performed during	DUR, of 4 cm or greater in diameter, per anal exc her 3 dimensional or 2 dimensional optic viewin g colonoscopy or by local excision, other than a 4, 32025, 32103 or 32106 applies (Anaes.) (Assi	g systems, if removal is unable to be service associated with a service to
22104		TN.8.17 of explanatory notes to this Category) $\mathbf{P}_{\text{cr}} = \mathbf{C}^{\mathbf{C}} + \mathbf{C}^{\mathbf{C}} + \mathbf{C}^{\mathbf{C}} + \mathbf{C}^{\mathbf{C}}$	
32104	Fee: \$1,015.65	Benefit: 75% = \$761.75 CARCINOMA per anal full thickness excision o	f (Anaes) (Assist)
32105	Fee: \$491.70	Benefit: 75% = \$368.80 85% = \$417.95	((111111 :5.) (1 :55151.)
	ANTEROLATE rectoscopy incor unable to be perf	RAL INTRAPERITONEAL RECTAL TUMOU porating either 3 dimensional or 2 dimensional of ormed during colonoscopy and if removal require a service associated with a service to which iter	ptic viewing systems, if removal is res dissection within the peritoneal
32106	(See para TN.8.31, Fee: \$1,386.45	TN.8.17 of explanatory notes to this Category) Benefit: 75% = \$1039.85 85% = \$1301.75	
	RECTAL TUMO	OUR, transsphincteric excision of (Kraske or sim	ilar operation) (Anaes.) (Assist.)
32108	Fee: \$1,015.65	Benefit: 75% = \$761.75	
	RECTAL PROL	APSE Delorme procedure for (Anaes.) (Assist.)	
32111	Fee: \$644.85	Benefit: 75% = \$483.65	
	RECTAL PROL	APSE, perineal recto-sigmoidectomy for (Anaes	s.) (Assist.)
32112	Fee: \$784.65	Benefit: 75% = \$588.50	
	RECTAL STRIC	TURE, per anal release of (Anaes.)	
32114	Fee: \$177.25 Benefit: 75% = \$132.95 85% = \$150.70		
		TURE, dilatation of (Anaes.)	
32115	Fee: \$128.90	Benefit: 75% = \$96.70	
		APSE, abdominal rectopexy of (Anaes.) (Assist.)
32117	Fee: \$1,015.65	Benefit: 75% = \$761.75	
52117		APSE, perineal repair of (Anaes.) (Assist.)	
22122			
32120	Fee: \$261.05	Benefit: 75% = \$195.80 JRE, anoplasty for (Anaes.) (Assist.)	
32123		The, anopiasty for (Anats.) (Assist.)	

T8. SUF	URGICAL OPERATIONS 2. COLORECTA		
	Fee: \$338.55	Benefit: 75% = \$253.95 85% = \$287.80	
	ANAL INCONT	TINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.)	
32126	Fee: \$491.70	Benefit: 75% = \$368.80	
	ANAL SPHINCTER, direct repair of (Anaes.) (Assist.)		
32129	Fee: \$644.85	Benefit: 75% = \$483.65	
	RECTOCELE, t	ransanal repair of rectocele (Anaes.) (Assist.)	
32131	Fee: \$542.15	Benefit: 75% = \$406.65	
	HAEMORRHO	IDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.)	
32132	Fee: \$45.80	Benefit: 75% = \$34.35 85% = \$38.95	
	HAEMORRHO	IDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, nfra red therapy for (Anaes.)	
32135	Fee: \$68.60	Benefit: 75% = \$51.45 85% = \$58.35	
	HAEMORRHO	IDECTOMY including excision of anal skin tags when performed (Anaes.)	
32138	Fee: \$373.65	Benefit: 75% = \$280.25 85% = \$317.65	
		IDECTOMY involving third or fourth degree haemorrhoids, including excision of anal performed (Anaes.) (Assist.)	
32139	Fee: \$373.65	Benefit: 75% = \$280.25	
	ANAL SKIN TA	AGS or ANAL POLYPS, excision of 1 or more of (Anaes.)	
32142	Fee: \$68.60	Benefit: 75% = \$51.45 85% = \$58.35	
	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre a hospital (Anaes.)		
32145	Fee: \$137.20	Benefit: 75% = \$102.90	
	PERIANAL TH	ROMBOSIS, incision of (Anaes.)	
32147	Fee: \$45.80	Benefit: 75% = \$34.35 85% = \$38.95	
	OPERATION FOR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.)		
32150	Fee: \$261.05	Benefit: 75% = \$195.80 85% = \$221.90	
		ATION OF, under general anaesthesia, with or without disimpaction of faeces, not being ted with a service to which another item in this Group applies (Anaes.)	
32153	Fee: \$71.20	Benefit: 75% = \$53.40	
	FISTULA-IN-A	NO, SUBCUTANEOUS, excision of (Anaes.)	
32156	Fee: \$133.85	Benefit: 75% = \$100.40 85% = \$113.80	
		A, treatment of, by excision or by insertion of a Seton, or by a combination of both lving the lower half of the anal sphincter mechanism (Anaes.) (Assist.)	
32159	Fee: \$338.55	Benefit: 75% = \$253.95	
32162	ANAL FISTUL	A, treatment of, by excision or by insertion of a Seton, or by a combination of both	

T8. SUF	RGICAL OPERATI	ONS	2. COLORECTAL
	procedures, invol	ving the upper half of the anal sphincter m	echanism (Anaes.) (Assist.)
	Fee: \$491.70	Benefit: 75% = \$368.80	
	ANAL FISTULA	, repair of, by mucosal flap advancement ((Anaes.) (Assist.)
32165	Fee: \$644.85	Benefit: 75% = \$483.65 85% = \$560.15	5
	ANAL FISTULA	- readjustment of Seton (Anaes.)	
32166	Fee: \$209.50	Benefit: 75% = \$157.15 85% = \$178.10)
	FISTULA WOUI (Anaes.)	ND, review of, under general or regional a	naesthetic, as an independent procedure
32168	Fee: \$133.85	Benefit: 75% = \$100.40	
		XAMINATION, with or without biopsy, uservice to which another item in this Grou	nder general anaesthetic, not being a service p applies (Anaes.)
32171	Fee: \$90.20	Benefit: 75% = \$67.65	
	INTR-AANAL, p	perianal or ischiorectal abscess, drainage o	f (excluding aftercare) (Anaes.)
32174	Fee: \$90.20	Benefit: 75% = \$67.65 85% = \$76.70	
		PERIANAL or ISCHIO-RECTAL ABSCE tal (excluding aftercare) (Anaes.)	SS, draining of, undertaken in the operating
32175	Fee: \$165.25	Benefit: 75% = \$123.95	
	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.)		al, where the time taken is less than or equal
32177	Fee: \$177.05	Benefit: 75% = \$132.80	
	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.)		
32180	Fee: \$261.05	Benefit: 75% = \$195.80	
	INTESTINAL SI	LING PROCEDURE prior to radiotherapy	(Anaes.) (Assist.)
32183	Fee: \$570.65	Benefit: 75% = \$428.00	
	COLONIC LAV	AGE, total, intra operative (Anaes.) (Assis	t.)
32186	Fee: \$570.65	Benefit: 75% = \$428.00	
	DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.)		
32200	Fee: \$300.45	Benefit: 75% = \$225.35 85% = \$255.40)
	ANAL OR PERI	NEAL GRACILOPLASTY (Anaes.) (Assi	ist.)
32203	Fee: \$645.15	Benefit: 75% = \$483.90	
	STIMULATOR A	AND ELECTRODES, insertion of, followi	ng previous graciloplasty (Anaes.) (Assist.)
32206	Fee: \$582.90	Benefit: 75% = \$437.20	

T8. SUF	RGICAL OPERATIONS	2. COLORECTAL	
	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimula (Assist.)	tor and electrodes (Anaes.)	
32209	Fee: \$936.70 Benefit: 75% = \$702.55		
	GRACILIS NEOSPHINCTER PACEMAKER, replacement of (Anae	s.)	
32210	Fee: \$259.55 Benefit: 75% = \$194.70 85% = \$220.65		
	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of performed in the operating theatre of a hospital, excluding aftercare (A		
32212	Fee: \$138.45 Benefit: 75% = \$103.85		
	Sacral nerve lead or leads, percutaneous placement using fluoroscopic intraoperative test stimulation, to manage faecal incontinence in a pati		
	a) has an anatomically intact but functionally deficient anal sphincter;	and	
	b) has faecal incontinence that has been refractory to conservative non months;	a-surgical treatment for at least 12	
	other than a patient who:		
	c) is medically unfit for surgery; or		
	d) is pregnant or planning pregnancy; or		
	e) has irritable bowel syndrome; or		
	f) has congenital anorectal malformations; or		
	g) has active anal abscesses or fistulas; or		
	h) has anorectal organic bowel disease, including cancer; or		
	i) has functional effects of previous pelvic irradiation; or		
	j) has congenital or acquired malformations of the sacrum; or		
	k) has had rectal or anal surgery within the previous 12 months (Anaes.)		
32213	Fee: \$671.55 Benefit: 75% = \$503.70		
	Neurostimulator or receiver, subcutaneous placement of, involving pla extension wire to a sacral nerve electrode using fluoroscopic guidance a patient who:		
	a) has an anatomically intact but functionally deficient anal sphincter;	and	
	b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 1 months;		
	other than a patient who:		
	c) is medically unfit for surgery; or		
20014	d) is pregnant or planning pregnancy; or		
32214			

T8. SUF	GICAL OPERATIONS	2. COLORECTAL
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months	
	(Anaes.) (Assist.)	
	Fee: \$339.35 Benefit: 75% = \$254.55	
	Sacral nerve electrode or electrodes, management, adjustment and electronic prog neurostimulator by a medical practitioner, to manage faecal incontinence, other th	
	a) is medically unfit for surgery; or	
	b) is pregnant or planning pregnancy; or	
	c) has irritable bowel syndrome; or	
	d) has congenital anorectal malformations; or	
	e) has active anal abscesses or fistulas; or	
	f) has anorectal organic bowel disease, including cancer; or	
	g) has functional effects of previous pelvic irradiation; or	
	h) has congenital or acquired malformations of the sacrum; or	
	i) has had rectal or anal surgery within the previous 12 months	
	–each day	
32215	Fee: \$127.40 Benefit: 75% = \$95.55 85% = \$108.30	
	Sacral nerve lead or leads, percutaneous surgical repositioning of, using fluorosco surgical repositioning of) and interoperative test stimulation, to correct displacem positioning, if the lead was inserted to manage faecal incontinence in a patient wh	ent or unsatisfactory
	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 lea months;	
	other than a patient who:	
	c) is medically unfit for surgery; or	
	d) is pregnant or planning pregnancy; or	
32216		

T8. SUF	RGICAL OPERATIONS 2	. COLORECTAL
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months	
	other than a service to which item 32213 applies	
	(Anaes.)	
	Fee: \$603.05 Benefit: 75% = \$452.30	
	Neurostimulator or receiver, removal of, if the neurostimulator or receiver was inserted incontinence in a patient who:	l 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 treatme months;	ent for at least 12
	other than a patient who:	
	c) is medically unfit for surgery; or	
	d) is pregnant or planning pregnancy; or	
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months	
	(Anaes.)	
32217	Fee: \$158.80 Benefit: 75% = \$119.10	
	Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incont who:	inence in a patient
	a) has an anatomically intact but functionally deficient anal sphincter; and	
32218	b) has faecal incontinence that has been refractory to conservative non-surgical treatme	ent for at least 12

2 COLORECTAL

T8. SUF	IRGICAL OPERATIONS 2. COL	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		
	(Anaes.)		
	Fee: \$158.80 Benefit: 75% = \$119.10		
	Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of a p whom conservative and other less invasive forms of treatment are contraindicated or have failed. Contraindicated in:	atient for	
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degener diseases or a scarred or fragile perineum; and	rative	
	(b) patients who have had an adverse reaction or radiopaque solution; and		
	(c) patients who enage in receptive anal intercourse (Anaes.) (Assist.)		
32220	Fee: \$918.35 Benefit: 75% = \$688.80 85% = \$833.65		
	Removal or revision of an artificial bowel sphincter (with or without replacement) for severe incontinence in the treatment of a patient for whom conservative and other less invasive form treatment are contraindicated or have failed. Contraindicated in:		
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degener diseases or a scarred or fragile perineum; and	rative	
	(b) patients who have had an adverse reaction to radiopaque solution; and		
	(c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)		
32221	Fee: \$918.35 Benefit: 75% = \$688.80 85% = \$833.65		
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient:		
	(a) following a positive faecal occult blood test; or		
32222	(b) who has symptoms consistent with pathology of the colonic mucosa; or		

T8. SUR	SURGICAL OPERATIONS 2. COLOREC		
	(c) with anaemia or iron deficiency; or		
	(d) for whom diagnostic imaging has shown an abnormality of the colon; or		
	(e) who is undergoing the first examination following surgery for colorectal cance	cer; or	
	(f) who is undergoing pre-operative evaluation; or		
	(g) for whom a repeat colonoscopy is required due to inadequate bowel preparation previous colonoscopy; or	on for the patient's	
	(h) for the management of inflammatory bowel disease		
	Applicable only once on a day under a single episode of anaesthesia or other seda	ation (Anaes.)	
	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) Fee: \$339.70 Benefit: 75% = \$254.80 85% = \$288.75		
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient	t:	
	(a) who has had a colonoscopy that revealed 1 to 4 adenomas, each of which wer diameter, had no villous features and had no high grade dysplasia; or	e less than 10mm in	
	(b) with a moderate risk of colorectal cancer due to family history; or		
	(c) with a history of colorectal cancer, who has had an initial post-operative color reveal any adenomas or colorectal cancer	noscopy that did not	
	Applicable only once in any 5 year period (Anaes.)		
32223	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) Fee: \$339.70 Benefit: 75% = \$254.80 85% = \$288.75		
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient of colorectal cancer due to:	t with a moderate risk	
	(a) a history of adenomas, including an adenoma that:		
	(i) was greater than 10mm in diameter; or		
	(ii) had villous features; or		
	(iii) had high grade dysplasia; or		
	(iv) was an advanced serrated adenoma; or		
	(b) having had a previous colonoscopy that revealed 5 to 9 adenomas, each of wh 10mm in diameter, had no villous features and had no high grade dysplasia	nich was less than	
	Applicable only once in any 3 year period (Anaes.)		
32224	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) Fee: \$339.70 Benefit: 75% = \$254.80 85% = \$288.75		
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient colorectal cancer due to having had a previous colonoscopy that:	t with a high risk of	
32225	(a) revealed 10 or more adenomas; or		

T8. SUF	RGICAL OPERATIONS	2. COLORECTAL
	(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.)	
	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) Fee: \$339.70 Benefit: 75% = \$254.80 85% = \$288.75	
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient w colorectal cancer due to:	rith a high risk of
	(a) a known or suspected familial condition, such as familial adenomatous polyposi or serrated polyposis syndrome; or	s, Lynch syndrome
	(b) a genetic mutation associated with hereditary colorectal cancer	
	Applicable only once in any 12 month period (Anaes.)	
32226	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) Fee: \$339.70 Benefit: 75% = \$254.80 85% = \$288.75	
	Endoscopic examination of the colon to the caecum by colonoscopy:	
	(a) for the treatment of bleeding, including one or more of the following:	
	(i) radiation proctitis;	
	(ii) angioectasia;	
	(iii) post-polypectomy bleeding; or	
	(b) for the treatment of colonic strictures with balloon dilatation	
	Applicable only once on a day under a single episode of anaesthesia or other sedation	on (Anaes.)
32227	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) Fee: \$476.70 Benefit: 75% = \$357.55 85% = \$405.20	
	Endoscopic examination of the colon to the caecum by colonoscopy, other that a se 32222, 32223, 32224, 32225, or 32226 applies. Applicable only once (Anaes.)	rvice to which item
32228	(See para TN.8.17, TN.8.2, TN.8.152 of explanatory notes to this Category) Fee: \$339.70 Benefit: 75% = \$254.80 85% = \$288.75	
	Removal of one or more polyps during colonoscopy, in association with a service to 32223, 32224, 32225, 32226, or 32228 applies	which item 32222,
	(Anaes.)	
32229	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) Fee: \$274.00 Benefit: 75% = \$205.50 85% = \$232.90	
T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	Group T8. Surgical Operations	
	Subgroup 3. Vascular	

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	VARICOSE VEINS	
	VARICOSE VEINS where varicosity measures 2.5mm or greater in diame sclerosant using continuous compression techniques, including associated not being a service associated with any other varicose vein operation on th care) - to a maximum of 6 treatments in a 12 month period (Anaes.)	consultation - 1 or both legs -
32500	(See para TN.8.4, TN.8.32 of explanatory notes to this Category) Fee: \$111.55 Benefit: 75% = \$83.70 85% = \$94.85 Extended Medicare Safety Net Cap: \$122.75	
	VARICOSE VEINS, multiple excision of tributaries, with or without divis veins - 1 leg - not being a service associated with a service to which item 3 32517 applies on the same leg (Anaes.)	sion of 1 or more perforating 32507, 32508, 32511, 32514 or
32504	(See para TN.8.32 of explanatory notes to this Category) Fee: \$271.95 Benefit: 75% = \$204.00 85% = \$231.20 Extended Medicare Safety Net Cap: \$217.60	
	VARICOSE VEINS, sub-fascial surgical exploration of one or more incor leg - not being a service associated with a service to which item 32508, 32 on the same leg (Anaes.) (Assist.)	
32507	(See para TN.8.32 of explanatory notes to this Category) Fee: \$542.15 Benefit: 75% = \$406.65 85% = \$460.85 Extended Medicare Safety Net Cap: \$433.75	
	VARICOSE VEINS, complete dissection at the sapheno-femoral OR saph with or without either ligation or stripping, or both, of the long or short sap time on the same leg, including excision or injection of either tributaries or veins, or both (Anaes.) (Assist.)	phenous veins, for the first
32508	(See para TN.8.32 of explanatory notes to this Category) Fee: \$542.15 Benefit: 75% = \$406.65	
	VARICOSE VEINS, complete dissection at the sapheno-femoral AND sap leg - with or without either ligation or stripping, or both, of the long or sho first time on the same leg, including excision or injection of either tributar veins, or both (Anaes.) (Assist.)	ort saphenous veins, for the
32511	(See para TN.8.32 of explanatory notes to this Category) Fee: \$806.00 Benefit: 75% = \$604.50	
	VARICOSE VEINS, ligation of the long or short saphenous vein on the sa stripping, by re-operation for recurrent veins in the same territory - 1 leg - of either tributaries or incompetent perforating veins, or both (Anaes.) (As	including excision or injection
32514	(See para TN.8.32 of explanatory notes to this Category) Fee: \$941.65 Benefit: 75% = \$706.25	
	VARICOSE VEINS, ligation of the long and short saphenous vein on the stripping, by re-operation for recurrent veins in either territory - 1 leg - inc either tributaries or incompetent perforating veins, or both (Anaes.) (Assist	eluding excision or injection of
32517	(See para TN.8.32 of explanatory notes to this Category)Fee: $\$1,212.50$ Benefit: $75\% = \$909.40$	
32520	Varicose veins, abolition of venous reflux by occlusion of a primary or rec (short) saphenous vein of one leg (and major tributaries of saphenous vein probe introduced by an endovenous catheter, if it is documented by duplex	s as necessary), using a laser

T8. SURGICAL OPERATIONS 3. VAS		3. VASCULAR
	small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5	5 seconds or longer:
	(a) including all preparation and immediate clinical aftercare (including exc tributaries or incompetent perforating veins, or both); and	cision or injection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or cya	noacrylate embolisation; and
	(c) not provided on the same occasion as a service described in any of items (Anaes.)	s 32500, 32504 and 32507
	(See para TN.8.33 of explanatory notes to this Category) Fee: \$542.15 Benefit: 75% = \$406.65 85% = \$460.85 Extended Medicare Safety Net Cap: \$81.35	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recu (short) saphenous vein of one leg (and major tributaries of saphenous veins probe introduced by an endovenous catheter, if it is documented by duplex small saphenous veins demonstrate reflux of 0.5 seconds or longer:	as necessary), using a laser
	(a) including all preparation and immediate clinical aftercare (including exc tributaries or incompetent perforating veins, or both); and	cision or injection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or cyan not provided on the same occasion as a service described in any of items 32 (Anaes.)	
32522	(See para TN.8.33 of explanatory notes to this Category) Fee: \$806.00 Benefit: 75% = \$604.50 85% = \$721.30 Extended Medicare Safety Net Cap: \$80.60	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recu (short) saphenous vein of one leg (and major tributaries of saphenous veins radiofrequency catheter introduced by an endovenous catheter, if it is docur that the great or small saphenous vein (whichever is to be treated) demonstr longer:	as necessary), using a mented by duplex ultrasound
	(a) including all preparation and immediate clinical aftercare (including exc tributaries or incompetent perforating veins, or both); and	cision or injection of either
	(b) not including endovenous laser therapy or cyanoacrylate embolisation; a	and
	(c) not provided on the same occasion as a service described in any of items (Anaes.)	s 32500, 32504 and 32507
32523	(See para TN.8.33 of explanatory notes to this Category) Fee: \$542.15 Benefit: 75% = \$406.65 85% = \$460.85 Extended Medicare Safety Net Cap: \$81.35	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recu (short) saphenous vein of one leg (and major tributaries of saphenous veins radiofrequency catheter introduced by an endovenous catheter, if it is docur that the great and small saphenous veins demonstrate reflux of 0.5 seconds	as necessary), using a mented by duplex ultrasound
	(a) including all preparation and immediate clinical aftercare (including exc tributaries or incompetent perforating veins, or both); and	cision or injection of either
32526	(b) not including endovenous laser therapy or cyanoacrylate embolisation; a	and

T8. SUR	GICAL OPERATIONS	3. VASCULAR
	(c) not provided on the same occasion as a service described in any of iter (Anaes.)	ms 32500, 32504 and 32507
	(See para TN.8.33 of explanatory notes to this Category) Fee: \$806.00 Benefit: 75% = \$604.50 85% = \$721.30 Extended Medicare Safety Net Cap: \$80.60	
	Varicose veins, abolition of venous reflux by occlusion of a primary or re (short) saphenous vein of one leg (and major tributaries of saphenous veir cyanoacrylate adhesive, if it is documented by duplex ultrasound that the (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer:	ns as necessary), using
	(a) including all preparation and immediate clinical aftercare (including extributaries or incompetent perforating veins, or both); and	xcision or injection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or er	ndovenous laser therapy; and
	(c) not provided on the same occasion as a service described in any of iter	ms 32500, 32504 and 32507
	(Anaes.)	
32528	(See para TN.8.33 of explanatory notes to this Category) Fee: \$542.15 Benefit: 75% = \$406.65 85% = \$460.85 Extended Medicare Safety Net Cap: \$81.35	
	Varicose veins, abolition of venous reflux by occlusion of a primary or re (short) saphenous vein of one leg (and major tributaries of saphenous vein cyanoacrylate adhesive, if it is documented by duplex ultrasound that the veins demonstrate reflux of 0.5 seconds or longer:	ns as necessary), using
	(a) including all preparation and immediate clinical aftercare (including extributaries or incompetent perforating veins, or both); and	xcision or injection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or er	ndovenous laser therapy; and
	(c) not provided on the same occasion as a service described in any of iter	ms 32500, 32504 and 32507
	(Anaes.)	
32529	(See para TN.8.33 of explanatory notes to this Category) Fee: \$806.00 Benefit: 75% = \$604.50 85% = \$721.30 Extended Medicare Safety Net Cap: \$80.60	
32329	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTEF	
	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (A	
32700	Fee: \$1,459.30 Benefit: 75% = \$1094.50	
	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or r reanastomosis of - with or without endarterectomy (Anaes.) (Assist.)	esection of small length and
32703	Fee: \$1,207.20 Benefit: 75% = \$905.40	
	AORTIC BYPASS for occlusive disease using a straight non-bifurcated g	graft (Anaes.) (Assist.)
32708	Fee: \$1,444.10 Benefit: 75% = \$1083.10	
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 o	r both anastomoses to the iliac

T8. SUF	RGICAL OPERATION	ONS 3. VASCULAF
	arteries (Anaes.) (Assist.)
	Fee: \$1,604.55	Benefit: 75% = \$1203.45
		S for occlusive disease using a bifurcated graft with 1 or both anastomoses to the or profunda femoris arteries (Anaes.) (Assist.)
32711	Fee: \$1,765.05	Benefit: 75% = \$1323.80
	ILIO-FEMORAL	BYPASS GRAFTING (Anaes.) (Assist.)
32712	Fee: \$1,275.90	Benefit: 75% = \$956.95
	AXILLARY or S ARTERIES (Ana	JBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL s.) (Assist.)
32715	Fee: \$1,275.90	Benefit: 75% = \$956.95
	FEMORO-FEMC	RAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.)
32718	Fee: \$1,207.20	Benefit: 75% = \$905.40
	RENAL ARTER	, bypass grafting to (Anaes.) (Assist.)
32721	Fee: \$1,917.55	Benefit: 75% = \$1438.20
	RENAL ARTERI	ES (both), bypass grafting to (Anaes.) (Assist.)
32724	Fee: \$2,177.40	Benefit: 75% = \$1633.05
	MESENTERIC V	ESSEL (single), bypass grafting to (Anaes.) (Assist.)
32730	Fee: \$1,650.30	Benefit: 75% = \$1237.75
	MESENTERIC V	ESSELS (multiple), bypass grafting to (Anaes.) (Assist.)
32733	Fee: \$1,917.55	Benefit: 75% = \$1438.20
	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intr abdominal vascular operation (Anaes.) (Assist.)	
32736	Fee: \$420.15	Benefit: 75% = \$315.15
		CRY BYPASS GRAFTING using vein, including harvesting of vein (when it is the henous vein) with above knee anastomosis (Anaes.) (Assist.)
32739	Fee: \$1,314.10	Benefit: 75% = \$985.60
		RY BYPASS GRAFTING using vein, including harvesting of vein (when it is the henous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.)
32742	Fee: \$1,505.20	Benefit: 75% = \$1128.90
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the henous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal sist.)
32745	Fee: \$1,719.00	Benefit: 75% = \$1289.25
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the henous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.)
32748	Fee: \$1,864.15	Benefit: 75% = \$1398.15

T8. SUF	RGICAL OPERATI	ONS 3. VASCU	JLAR
	FEMORAL ART below the knee (A	ERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above (Anaes.) (Assist.)	or
32751	Fee: \$1,207.20	Benefit: 75% = \$905.40	
		ERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) is above or below the knee, including use of a cuff or sleeve of vein at 1 or both aes.) (Assist.)) with
32754	Fee: \$1,505.20	Benefit: 75% = \$1128.90	
	an additional ana	ERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) stomosis is made to separately revascularise more than 1 artery - each additional a yond a femoral bypass (Anaes.) (Assist.)	
32757	Fee: \$420.15	Benefit: 75% = \$315.15	
		TING OF, FROM LEG OR ARM for bypass or replacement graft when not perfor n is the subject of the bypass or graft - each vein (Anaes.) (Assist.)	rmed
32760	Fee: \$412.55	Benefit: 75% = \$309.45	
		PASS GRAFTING, using vein or synthetic material, not being a service to which is Sub-group applies (Anaes.) (Assist.)	
32763	Fee: \$1,207.20	Benefit: 75% = \$905.40	
		VENOUS ANASTOMOSIS, not being a service to which another item in this Sub an independent procedure (Anaes.) (Assist.))-
32766	Fee: \$802.30	Benefit: 75% = \$601.75	
		VENOUS ANASTOMOSIS not being a service to which another item in this Sub- nen performed in combination with another vascular operation (including graft to g naes.) (Assist.)	
32769	Fee: \$278.05	Benefit: 75% = \$208.55	
		BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS	
		TING to replace a popliteal aneurysm using vein, including harvesting vein (when g saphenous vein) (Anaes.) (Assist.)	it is
33050	Fee: \$1,478.60	Benefit: 75% = \$1108.95	
	BYPASS GRAF	FING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.)	
33055	Fee: \$1,185.70	Benefit: 75% = \$889.30	
		THE EXTREMITIES, ligation, suture closure or excision of, without bypass graft	ting
33070	Fee: \$855.45	Benefit: 75% = \$641.60 85% = \$770.75	
	ANEURYSM IN (Assist.)	THE NECK, ligation, suture closure or excision of, without bypass grafting (Ana	es.)
33075	Fee: \$1,088.20	Benefit: 75% = \$816.15	
		INAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without	
	bypass grafting (A		

T8. SUF	RGICAL OPERATIO	NS 3. VASCULAR
		COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft material (Anaes.) (Assist.)
33100	Fee: \$1,459.30	Benefit: 75% = \$1094.50 85% = \$1374.60
	THORACIC ANE	URYSM, replacement by graft (Anaes.) (Assist.)
33103	Fee: \$2,047.55	Benefit: 75% = \$1535.70
	THORACO-ABDO (Anaes.) (Assist.)	DMINAL ANEURYSM, replacement by graft including re-implantation of arteries
33109	Fee: \$2,475.50	Benefit: 75% = \$1856.65 85% = \$2390.80
	SUPRARENAL Al of arteries (Anaes.)	BDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation (Assist.)
33112	Fee: \$2,146.90	Benefit: 75% = \$1610.20
		BDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service ervice to which item 33116 applies (Anaes.) (Assist.)
33115	Fee: \$1,444.10	Benefit: 75% = \$1083.10
		BDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular acluding associated radiological services (Anaes.) (Assist.)
33116	Fee: \$1,421.40	Benefit: 75% = \$1066.05 85% = \$1336.70
	arteries (with or wi	BDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac thout excision of common iliac aneurysms) not being a service associated with a em 33119 applies (Anaes.) (Assist.)
33118	Fee: \$1,604.55	Benefit: 75% = \$1203.45
		BDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both endovascular repair procedure, excluding associated radiological services (Anaes.)
33119	Fee: \$1,579.40	Benefit: 75% = \$1184.55 85% = \$1494.70
		BDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both ith or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.)
33121	Fee: \$1,765.05	Benefit: 75% = \$1323.80
	ANEURYSM OF I (Anaes.) (Assist.)	LIAC ARTERY (common, external or internal), replacement by graft - unilateral
33124	Fee: \$1,230.15	Benefit: 75% = \$922.65
	ANEURYSMS OF (Anaes.) (Assist.)	ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral
33127	Fee: \$1,612.15	Benefit: 75% = \$1209.15 85% = \$1527.45
	ANEURYSM OF v graft (Anaes.) (Ass	VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by ist.)
33130	Fee: \$1,405.80	Benefit: 75% = \$1054.35
33133	ANEURYSM OF	VISCERAL ARTERY, dissection and ligation of arteries without restoration of

T8. SUF	URGICAL OPERATIONS 3. VASC		
	continuity (Anaes.) (Assist.)	
	Fee: \$1,054.25	Benefit: 75% = \$790.70	
	FALSE ANEURY (Assist.)	SM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.)	
33136	Fee: \$2,658.60	Benefit: 75% = \$1993.95	
	FALSE ANEURY	SM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.)	
33139	Fee: \$1,612.15	Benefit: 75% = \$1209.15	
	FALSE ANEURY	SM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.)	
33142	Fee: \$1,505.20	Benefit: 75% = \$1128.90 85% = \$1420.50	
	RUPTURED THO	DRACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	
33145	Fee: \$2,590.00	Benefit: 75% = \$1942.50	
		DRACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.)	
33148	Fee: \$3,216.45	Benefit: 75% = \$2412.35	
	RUPTURED SUP (Assist.)	RARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.)	
33151	Fee: \$3,056.05	Benefit: 75% = \$2292.05	
	RUPTURED INFI (Anaes.) (Assist.)	RARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft	
33154	Fee: \$2,261.50	Benefit: 75% = \$1696.15	
		RARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft ith or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.)	
33157	Fee: \$2,521.20	Benefit: 75% = \$1890.90	
		RARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft al arteries (Anaes.) (Assist.)	
33160	Fee: \$2,521.20	Benefit: 75% = \$1890.90	
	RUPTURED ILIA	C ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.)	
33163	Fee: \$2,139.40	Benefit: 75% = \$1604.55	
	RUPTURED ANE (Assist.)	EURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.)	
33166	Fee: \$2,139.40	Benefit: 75% = \$1604.55 85% = \$2054.70	
	RUPTURED ANE	EURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.)	
33169	Fee: \$1,665.60	Benefit: 75% = \$1249.20	
	ANEURYSM OF	MAJOR ARTERY, replacement by graft, not being a service to which another item in blies (Anaes.) (Assist.)	
33172	Fee: \$1,298.80	Benefit: 75% = \$974.10	

T8. SUF	GICAL OPERATIO	ONS 3. VA	SCULAR
	RUPTURED ANE bypass grafting (A	EURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, w naes.) (Assist.)	without
33175	Fee: \$1,196.95	Benefit: 75% = \$897.75	
	RUPTURED ANE grafting (Anaes.) (EURYSM IN THE NECK, ligation, suture closure or excision of, without by Assist.)	pass
33178	Fee: \$1,522.15	Benefit: 75% = \$1141.65	
		RA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or e affting (Anaes.) (Assist.)	excision of,
33181	Fee: \$1,861.00	Benefit: 75% = \$1395.75	
		ENDARTERECTOMY AND ARTERIAL PATCH	
		TERIES OF NECK, endarterectomy of, including closure by suture (where 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (A	Assist.)
33500	Fee: \$1,153.55	Benefit: 75% = \$865.20	
	INNOMINATE O (Assist.)	R SUBCLAVIAN ARTERY, endarterectomy of, including closure by sutur	re (Anaes.)
33506	Fee: \$1,291.25	Benefit: 75% = \$968.45	
		TERECTOMY, including closure by suture, not being a service associated v on the aorta (Anaes.) (Assist.)	with
33509	Fee: \$1,444.10	Benefit: 75% = \$1083.10	
		NDARTERECTOMY (1 or both iliac arteries), including closure by suture with a service to which item 33515 applies (Anaes.) (Assist.)	not being a
33512	Fee: \$1,604.55	Benefit: 75% = \$1203.45	
	FEMORAL END	AL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL IL ARTERECTOMY, including closure by suture, not being a service associate em 33512 applies (Anaes.) (Assist.)	
33515	Fee: \$1,765.05	Benefit: 75% = \$1323.80	
		ERECTOMY, including closure by suture, not being a service associated with liac artery (Anaes.) (Assist.)	th another
33518	Fee: \$1,291.25	Benefit: 75% = \$968.45 85% = \$1206.55	
	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.)		
33521	Fee: \$1,398.10	Benefit: 75% = \$1048.60	
	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.)		
33524	Fee: \$1,650.30	Benefit: 75% = \$1237.75	
<i>3332</i> 4		ES (both), endarterectomy of (Anaes.) (Assist.)	
22527			
33527	Fee: \$1,917.55	Benefit: 75% = \$1438.20 PERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)	
33530	Fee: \$1,650.30	Benefit: 75% = \$1237.75	

T8. SUF	GICAL OPERATION	ONS	3. VASCULAR
	COELIAC AND	SUPERIOR MESENTERIC ARTERY, endarterectomy of (A	Anaes.) (Assist.)
33533	Fee: \$1,917.55	Benefit: 75% = \$1438.20	
		ENTERIC ARTERY, endarterectomy of, not being a service item in this Sub-group applies (Anaes.) (Assist.)	associated with a service
33536	Fee: \$1,367.65	Benefit: 75% = \$1025.75	
	ARTERY OF EX	TREMITIES, endarterectomy of, including closure by suture	e (Anaes.) (Assist.)
33539	Fee: \$985.55	Benefit: 75% = \$739.20	
	EXTENDED DEI (Anaes.) (Assist.)	EP FEMORAL ENDARTERECTOMY where the endartered	ctomy is at least 7cms long
33542	Fee: \$1,405.80	Benefit: 75% = \$1054.35	
		OR BYPASS GRAFT, patch grafting to by vein or synthetic g (Anaes.) (Assist.)	e material where patch is
33545	(See para TN.8.36 c Fee: \$278.05	of explanatory notes to this Category) Benefit: 75% = \$208.55	
		OR BYPASS GRAFT, patch grafting to by vein or synthetic er (Anaes.) (Assist.)	material where patch is
33548	(See para TN.8.36 c Fee: \$565.50	of explanatory notes to this Category) Benefit: 75% = \$424.15	
	VEIN, harvesting (Anaes.) (Assist.)	of from leg or arm for patch when not performed through sa	me incision as operation
33551	(See para TN.8.36 c Fee: \$278.05	of explanatory notes to this Category) Benefit: 75% = \$208.55	
		OMY, in conjunction with an arterial bypass operation to prohibite (Anaes.) (Assist.)	epare the site for
33554	Fee: \$276.75	Benefit: 75% = \$207.60	
		EMBOLECTOMY, THROMBECTOMY AND VASCULAR T	RAUMA
	EMBOLUS, remo	oval of, from artery of neck (Anaes.) (Assist.)	
33800	Fee: \$1,199.50	Benefit: 75% = \$899.65 85% = \$1114.80	
EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or b trunk (Anaes.) (Assist.)		ery or bypass graft of	
33803	Fee: \$1,146.10	Benefit: 75% = \$859.60	
	or bypass graft of	hrombectomy (including the infusion of thrombolytic or oth extremities, or embolectomy of abdominal artery via the fen extremity, regardless of the number of incisions required to a ssist.)	noral artery, item to be
33806	Fee: \$825.15	Benefit: 75% = \$618.90 85% = \$740.45	
	INFERIOR VENA (Anaes.) (Assist.)	A CAVA OR ILIAC VEIN, closed thrombectomy by cathete	er via the femoral vein
33810	Fee: \$601.95	Benefit: 75% = \$451.50 85% = \$517.25	

T8. SUF	GICAL OPERATIC	DNS	3. VASCULAR
	INFERIOR VENA	CAVA OR ILIAC VEIN, open removal of thro	mbus or tumour (Anaes.) (Assist.)
33811	Fee: \$1,792.00	Benefit: 75% = \$1344.00	
	THROMBUS, rem	oval of, from femoral or other similar large vein	(Anaes.) (Assist.)
33812	Fee: \$947.35	Benefit: 75% = \$710.55 85% = \$862.65	
	MAJOR ARTERY lateral suture (Ana	OR VEIN OF EXTREMITY, repair of wound of es.) (Assist.)	of, with restoration of continuity, by
33815	Fee: \$871.00	Benefit: 75% = \$653.25	
	MAJOR ARTERY direct anastomosis	OR VEIN OF EXTREMITY, repair of wound of (Anaes.) (Assist.)	of, with restoration of continuity, by
33818	Fee: \$1,016.15	Benefit: 75% = \$762.15	
		OR VEIN OF EXTREMITY, repair of wound of synthetic material or vein (Anaes.) (Assist.)	of, with restoration of continuity, by
33821	Fee: \$1,161.30	Benefit: 75% = \$871.00	
	MAJOR ARTERY suture (Anaes.) (A	OR VEIN OF NECK, repair of wound of, with ssist.)	restoration of continuity, by lateral
33824	Fee: \$1,107.80	Benefit: 75% = \$830.85	
	MAJOR ARTERY anastomosis (Anae	OR VEIN OF NECK, repair of wound of, with s.) (Assist.)	restoration of continuity, by direct
33827	Fee: \$1,298.80	Benefit: 75% = \$974.10	
		OR VEIN OF NECK, repair of wound of, with of synthetic material or vein (Anaes.) (Assist.)	restoration of continuity, by
33830	Fee: \$1,489.75	Benefit: 75% = \$1117.35	
	MAJOR ARTERY lateral suture (Ana	OR VEIN OF ABDOMEN, repair of wound of, es.) (Assist.)	, with restoration of continuity by
33833	Fee: \$1,352.45	Benefit: 75% = \$1014.35	
	MAJOR ARTERY direct anastomosis	OR VEIN OF ABDOMEN, repair of wound of, (Anaes.) (Assist.)	, with restoration of continuity by
33836	Fee: \$1,612.15	Benefit: 75% = \$1209.15	
		OR VEIN OF ABDOMEN, repair of wound of, tion graft (Anaes.) (Assist.)	, with restoration of continuity by
33839	Fee: \$1,887.10	Benefit: 75% = \$1415.35	
	ARTERY OF NEC (Anaes.) (Assist.)	CK, re-operation for bleeding or thrombosis after	carotid or vertebral artery surgery
33842	Fee: \$932.10	Benefit: 75% = \$699.10	
		for control of post operative bleeding or thrombon to other procedure is performed (Anaes.) (Assist	
33845	Fee: \$649.45	Benefit: 75% = \$487.10	
33848	EXTREMITY, re-	operation on, for control of bleeding or thrombos	sis after vascular procedure, where no

T8. SUF	RGICAL OPERATIO	DNS	3. VASCULAR	
	other procedure is	performed (Anaes.) (Assist.)		
	Fee: \$649.45	Benefit: 75% = \$487.10		
	LIGA	TION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF	- VESSELS	
		⁷ OF NECK, elective ligation or exploration of, not being a ser procedure (Anaes.) (Assist.)	vice associated with	
34100	Fee: \$718.30	Benefit: 75% = \$538.75		
	exploration of imr iliac, femoral or p 32520, 32522, 325	or pulmonary artery) or great vein (superior or inferior vena c nediate branches or tributaries, or ligation or exploration of the opliteal arteries or veins, if the service is not associated with ite 23, 32526, 32528 or 32529 - for a maximum of 2 services pro e occasion (H) (Anaes.) (Assist.)	subclavian, axillary, em 32508, 32511,	
34103	Fee: \$420.15	Benefit: 75% = \$315.15		
	exploration of, not	IN (including brachial, radial, ulnar or tibial), ligation of, by el- being a service associated with any other vascular procedure of 3, 32511, 32514 or 32517 apply (Anaes.) (Assist.)		
34106	Fee: \$296.35 Extended Medica	Benefit: 75% = \$222.30 85% = \$251.90 re Safety Net Cap: \$237.10		
	TEMPORAL AR	TERY, biopsy of (Anaes.) (Assist.)		
34109	Fee: \$343.75	Benefit: 75% = \$257.85 85% = \$292.20		
	ARTERIO-VENC	US FISTULA OF AN EXTREMITY, dissection and ligation ((Anaes.) (Assist.)	
34112	Fee: \$871.00	Benefit: 75% = \$653.25		
	ARTERIO-VENC	US FISTULA OF THE NECK, dissection and ligation (Anaes	.) (Assist.)	
34115	Fee: \$985.55	Benefit: 75% = \$739.20		
	ARTERIO-VENC	US FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.)	
34118	Fee: \$1,405.80	Benefit: 75% = \$1054.35 85% = \$1321.10		
		US FISTULA OF AN EXTREMITY, dissection and repair of) (Assist.)	, with restoration of	
34121	Fee: \$1,123.05	Benefit: 75% = \$842.30		
	ARTERIO-VENC (Anaes.) (Assist.)	US FISTULA OF THE NECK, dissection and repair of, with	restoration of continuity	
34124	Fee: \$1,230.15	Benefit: 75% = \$922.65		
	ARTERIO-VENC continuity (Anaes	US FISTULA OF THE ABDOMEN, dissection and repair of,) (Assist.)	with restoration of	
34127	Fee: \$1,612.15	Benefit: 75% = \$1209.15		
	SURGICALLY C (Assist.)	REATED ARTERIO-VENOUS FISTULA OF AN EXTREM	TY, closure of (Anaes.)	
34130	Fee: \$504.25	Benefit: 75% = \$378.20 85% = \$428.65		
34133	SCALENOTOMY	(Anaes.) (Assist.)		

T8. SUF	RGICAL OPERAT	ONS 3. VASCULA
	Fee: \$565.50	Benefit: 75% = \$424.15
	FIRST RIB, rese	ction of portion of (Anaes.) (Assist.)
34136	Fee: \$909.05	Benefit: 75% = \$681.80
		, removal of, or other operation for removal of thoracic outlet compression, not being a another item in this Sub-group applies (Anaes.) (Assist.)
34139	Fee: \$909.05	Benefit: 75% = \$681.80
	COELIAC ARTI procedure (Anae	ERY, decompression of, for coeliac artery compression syndrome, as an independent a.) (Assist.)
34142	Fee: \$1,123.05	Benefit: 75% = \$842.30
		TERY, exploration of, for popliteal entrapment, with or without division of fibrous (Anaes.) (Assist.)
34145	Fee: \$817.50	Benefit: 75% = \$613.15
		OCIATED TUMOUR, resection of, with or without repair or reconstruction of internal id arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.)
34148	Fee: \$1,459.30	Benefit: 75% = \$1094.50
		OCIATED TUMOUR, resection of, with or without repair or reconstruction of internal id arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.)
34151	Fee: \$1,994.05	Benefit: 75% = \$1495.55
		AROTID ASSOCIATED TUMOUR, resection of, with or without repair or ortion of internal or common carotid arteries (Anaes.) (Assist.)
34154	Fee: \$2,376.15	Benefit: 75% = \$1782.15 85% = \$2291.45
	NECK, excision	of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.)
34157	Fee: \$1,207.20	Benefit: 75% = \$905.40
		ENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.)
34160	Fee: \$2,261.50	Benefit: 75% = \$1696.15
		ENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum
34163	Fee: \$2,903.25	Benefit: 75% = \$2177.45
		ENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and grafting (Anaes.) (Assist.)
34166	Fee: \$2,903.25	Benefit: 75% = \$2177.45
	INFECTED BYE (Assist.)	ASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.)
34169	Fee: \$1,612.15	Benefit: 75% = \$1209.15
	INFECTED AXI arteries (Anaes.)	LLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of (Assist.)
34172	Fee: \$1,314.10	Benefit: 75% = \$985.60

T8. SUF	RGICAL OPERATION	ONS	3. VASCULAF
	INFECTED BYP (Anaes.) (Assist.)	ASS GRAFT FROM EXTREMITIES, excision of	including closure of arteries
34175	Fee: \$1,207.20	Benefit: 75% = \$905.40	
		OPERATIONS FOR VASCULAR ACC	CESS
	ARTERIOVENO	US SHUNT, EXTERNAL, insertion of (Anaes.) (A	Assist.)
34500	Fee: \$313.35	Benefit: 75% = \$235.05 85% = \$266.35	
		US ANASTOMOSIS OF UPPER OR LOWER LI operation (Anaes.) (Assist.)	MB, in conjunction with another
34503	Fee: \$420.15	Benefit: 75% = \$315.15	
	ARTERIOVENO	US SHUNT, EXTERNAL, removal of (Anaes.) (A	Assist.)
34506	Fee: \$213.80	Benefit: 75% = \$160.35	
		US ANASTOMOSIS OF UPPER OR LOWER LI arterial operation (Anaes.) (Assist.)	MB, not in conjunction with
34509	Fee: \$993.20	Benefit: 75% = \$744.90	
	ARTERIOVENO	US ACCESS DEVICE, insertion of (Anaes.) (Assi	ist.)
34512	Fee: \$1,092.60	Benefit: 75% = \$819.45	
		US ACCESS DEVICE, thrombectomy of (Anaes.)	(Assist.)
34515	Fee: \$779.25	Benefit: 75% = \$584.45	
		RTERIOVENOUS FISTULA OR PROSTHETIC ion of (Anaes.) (Assist.)	ARTERIOVENOUS ACCESS
34518	Fee: \$1,306.30	Benefit: 75% = \$979.75	
		INAL ARTERY OR VEIN, cannulation of, for inf ing aftercare) (Anaes.) (Assist.)	usion chemotherapy, by open
34521	(See para TN.8.4 of Fee: \$802.60	explanatory notes to this Category) Benefit: 75% = \$601.95	
	ARTERIAL CAN which item 34521	NULATION for infusion chemotherapy by open of applies (excluding after-care) (Anaes.) (Assist.)	operation, not being a service to
34524	(See para TN.8.4 of Fee: \$420.15	explanatory notes to this Category) Benefit: 75% = \$315.15	
	access port as wit	CATHETERISATION by open technique, using a h central venous line catheter or other chemotherap aneous central vein catheterization, on a person 10	by delivery device, including any
34527	Fee: \$560.45	Benefit: 75% = \$420.35 85% = \$476.40	
	pump or access po	CATHETERISATION by percutaneous technique ort as with central venous line catheter or other che f age or over (Anaes.)	
34528	Fee: \$276.75	Benefit: 75% = \$207.60 85% = \$235.25	
34529	CENTRAL VEIN	CATHETERISATION by open technique, using the central venous line catheter or other chemotherap	

associated percuta			
	aneous central vein catheter	ization, on a person under 10 years of age (Anaes.)	
Fee: \$728.55	Benefit: 75% = \$546.45	85% = \$643.85	
			al
Fee: \$207.50	Benefit: 75% = \$155.65	85% = \$176.40	
procedure, region	al perfusion for chemothera	py, or other therapy, repair of arteriotomy and venotomy	y at
Fee: \$1,260.50	Benefit: 75% = \$945.40	85% = \$1175.80	
pump or access p	ort as with central venous lin		
Fee: \$359.75	Benefit: 75% = \$269.85	85% = \$305.80	
Fee: \$276.75	Benefit: 75% = \$207.60	85% = \$235.25	
TUNNELLED C (Anaes.)	UFFED CATHETER, OR S	SIMILAR DEVICE, removal of, by open surgical proced	lure
Fee: \$207.50	Benefit: 75% = \$155.65	85% = \$176.40	
			al
Fee: \$269.75	Benefit: 75% = \$202.35	85% = \$229.30	
	COMPLEX	VENOUS OPERATIONS	
INFERIOR VEN	A CAVA, plication, ligation	n, or application of caval clip (Anaes.) (Assist.)	
Fee: \$825.15	Benefit: 75% = \$618.90	85% = \$740.45	
INFERIOR VEN	A CAVA, reconstruction of	for bypass by vein or synthetic material (Anaes.) (Assist	.)
Fee: \$1,818.50	Benefit: 75% = \$1363.90)	
CROSS LEG BY	PASS GRAFTING, saphene	ous to iliac or femoral vein (Anaes.) (Assist.)	
Fee: \$985.55	Benefit: 75% = \$739.20		
SAPHENOUS VI (Assist.)	EIN ANASTOMOSIS to fer	moral or popliteal vein for femoral vein bypass (Anaes.)	
Fee: \$985.55	Benefit: 75% = \$739.20		
			a
Fee: \$1,191.80	Benefit: 75% = \$893.85		
		cluding vein graft stenosis)-using vein or synthetic mate	rial
(See para TN.8.36 c	of explanatory notes to this Cat	tegory)	
	procedure in the ofFee: \$207.50ISOLATED LIMprocedure, regionconclusion of proFee: \$1,260.50CENTRAL VEINpump or access pperson under 10 yFee: \$359.75CENTRAL VEINcuffed catheter orFee: \$276.75TUNNELLED CU(Anaes.)Fee: \$207.50CENTRAL VENprocedure in the ofFee: \$269.75INFERIOR VENFee: \$1,818.50CROSS LEG BYFee: \$985.55SAPHENOUS VI(Assist.)Fee: \$985.55VENOUS STENOvein STENOSIS(Anaes.) (Assist.)	procedure in the operating theatre of a hospitFee: \$207.50Benefit: 75% = \$155.65ISOLATED LIMB PERFUSION, including a procedure, regional perfusion for chemothera conclusion of procedure (excluding aftercare fee: \$1,260.50Benefit: 75% = \$945.40CENTRAL VEIN CATHETERISATION by pump or access port as with central venous li person under 10 years of age (Anaes.)Fee: \$359.75Benefit: 75% = \$269.85CENTRAL VEIN CATHERTERISATION to cuffed catheter or similar device, for the admFee: \$276.75Benefit: 75% = \$207.60TUNNELLED CUFFED CATHETER, OR S (Anaes.)Fee: \$207.50Benefit: 75% = \$155.65CENTRAL VENOUS LINE, OR OTHER C procedure in the operating theatre of a hospitFee: \$207.50Benefit: 75% = \$155.65CENTRAL VENOUS LINE, OR OTHER C procedure in the operating theatre of a hospitFee: \$269.75Benefit: 75% = \$202.35COMPLE>INFERIOR VENA CAVA, plication, ligationFee: \$825.15Benefit: 75% = \$1363.90INFERIOR VENA CAVA, reconstruction ofFee: \$985.55Benefit: 75% = \$739.20VENOUS STENOSIS OR OCCLUSION, ve service associated with a service to which iteFee: \$985.55Benefit: 75% = \$739.20VENOUS STENOSIS OR OCCLUSION, ve service associated with a	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy conclusion of procedure (excluding aftercare) (Anaes.) (Assist.) Fee: \$1,260.50 Benefit: 75% = \$945.40 85% = \$1175.80 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 person under 10 years of age (Anaes.) Fee: \$359.75 Benefit: 75% = \$269.85 85% = \$305.80 CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with quift catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.) Fee: \$276.75 Benefit: 75% = \$207.60 85% = \$235.25 TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical proced (Anaes.) Fee: \$207.50 Benefit: 75% = \$155.65 85% = \$176.40 CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgice procedure in the operating theatre of a hospital, on a person under 10 years of age (Anaes.) Fee: \$269.75 Benefit: 75% = \$202.35 85% = \$229.30 COMPLEX VENOUS OPERATIONS INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) Fee: \$825.15 Benefit: 75% = \$1363.90 CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) Fee: \$985.55 Benefit: 75% = \$739.20 SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) Fee: \$985.55 Benefit: 75% = \$739.20 VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.) Fee: \$1,191.80 Benefit: 75% = \$893.85 VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material, not being service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.)

T8. SUF	RGICAL OPERAT	IONS 3. VASCULAR		
	Fee: \$985.55	Benefit: 75% = \$739.20		
	VENOUS VALV	/E, plication or repair to restore valve competency (Anaes.) (Assist.)		
34818	Fee: \$1,084.90	Benefit: 75% = \$813.70		
	VEIN TRANSPI	LANT to restore valvular function (Anaes.) (Assist.)		
34821	Fee: \$1,474.65	Benefit: 75% = \$1106.00 85% = \$1389.95		
54621		ENT, application of, to restore venous valve competency to superficial vein - 1 stent		
	(Anaes.) (Assist.)			
34824	Fee: \$504.25	Benefit: 75% = \$378.20		
		ENTS, application of, to restore venous valve competency to superficial vein or veins - t (Anaes.) (Assist.)		
34827	Fee: \$611.30	Benefit: 75% = \$458.50		
	EXTERNAL ST (Assist.)	ENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.)		
34830	Fee: \$718.30	Benefit: 75% = \$538.75 85% = \$633.60		
	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more			
	than 1 stent) (An	aes.) (Assist.)		
34833	Fee: \$932.10	Benefit: 75% = \$699.10		
		SYMPATHECTOMY		
	LUMBAR SYM	PATHECTOMY (Anaes.) (Assist.)		
35000	Fee: \$718.30	Benefit: 75% = \$538.75 85% = \$633.60		
	CERVICAL OR (Assist.)	UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.)		
35003	Fee: \$932.10	Benefit: 75% = \$699.10		
		UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for lete sympathectomy by any surgical approach (Anaes.) (Assist.)		
35006	Fee: \$1,168.95	Benefit: 75% = \$876.75		
		PATHECTOMY, where operation is following chemical sympathectomy or for lete surgical sympathectomy (Anaes.) (Assist.)		
35009	Fee: \$909.05	Benefit: 75% = \$681.80		
	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.)			
35012	Fee: \$718.30	Benefit: 75% = \$538.75		
		DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE		
		MB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating ital, when debridement includes muscle, tendon or bone (Anaes.) (Assist.)		
35100	Fee: \$374.45	Benefit: 75% = \$280.85		
25102		MB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating ital, superficial tissue only (Anaes.)		
35103				

T8. SUF	RGICAL OPERAT	IONS	3. VASCULAR	
	Fee: \$238.30	Benefit: 75% = \$178.75		
		MISCELLANEOUS VASCULAR PROCEDUR	ES	
		RTERIOGRAPHY OR VENOGRAPHY, 1 or more of, percedure on an artery or vein, 1 site (Anaes.)	erformed during the course of	
35200	Fee: \$174.25	Benefit: 75% = \$130.70		
		RIES OR VEINS IN THE NECK, ABDOMEN OR EXTR N after prior surgery on these vessels (Anaes.) (Assist.)	EMITIES, access to, as part of	
35202	Fee: \$830.15	Benefit: 75% = \$622.65		
		ENDOVASCULAR INTERVENTIONAL PROCED	URES	
		AL BALLOON ANGIOPLASTY of 1 peripheral artery o sure, excluding associated radiological services or prepara)		
35300	Fee: \$523.60	Benefit: 75% = \$392.70 85% = \$445.10		
	more than 1 perip	AL BALLOON ANGIOPLASTY of aortic arch branches, pheral artery or vein of 1 limb, percutaneous or by open e ices or preparation, and excluding aftercare (Anaes.) (Ass	xposure, excluding associated	
35303	Fee: \$671.35	Benefit: 75% = \$503.55 85% = \$586.65		
	peripheral artery	AL STENT INSERTION, 1 or more stents, including asso or vein of 1 limb, percutaneous or by open exposure, exc aration, and excluding aftercare. (Anaes.) (Assist.)		
35306	Fee: \$619.65	Benefit: 75% = \$464.75 85% = \$534.95		
	associated balloc	AL STENT INSERTION, 1 or more stents (not drug-elution dilatation, for 1 carotid artery, percutaneous (not direct) on device, in patients who:		
	- meet the indications for carotid endarterectomy; and			
		or surgical comorbidities that would make them at high r om carotid endarterectomy,	isk of perioperative	
	excluding associ	ated radiological services or preparation, and excluding a	ftercare (Anaes.) (Assist.)	
35307	(See para TN.8.37 Fee: \$1,139.10	of explanatory notes to this Category) Benefit: 75% = \$854.35		
	visceral arteries	AL STENT INSERTION, 1 or more stents, including asso or veins, or more than 1 peripheral artery or vein of 1 limb ling associated radiological services or preparation, and ex	o, percutaneous or by open	
35309	Fee: \$774.55	Benefit: 75% = \$580.95 85% = \$689.85		
	percutaneous or	ARTERIAL ATHERECTOMY including associated ballo by open exposure, excluding associated radiological servi are (Anaes.) (Assist.)		
35312	Fee: \$877.85	Benefit: 75% = \$658.40		
		ASER ANGIOPLASTY including associated balloon dil		

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	or by open exposure, excluding associated radiological services or preparati (Anaes.) (Assist.)	ion, and excluding aftercare
	Fee: \$877.85 Benefit: 75% = \$658.40	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with adr or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percuta associated radiological services or preparation, and excluding aftercare (not with a service to which another item in Subgroup 11 of Group T1 or items 3 not being a service associated with photodynamic therapy with verteporfin)	aneous approach, excluding t being a service associated 35319 or 35320 applies and
35317	(See para TN.8.38 of explanatory notes to this Category) Fee: \$361.50 Benefit: 75% = \$271.15 85% = \$307.30	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with add or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using perce excluding associated radiological services or preparation, and excluding aft associated with a service to which another item in Subgroup 11 of Group T applies and not being a service associated with photodynamic therapy with (Assist.)	eutaneous approach, ercare (not being a service 1 or items 35317 or 35320
35319	Fee: \$648.00 Benefit: 75% = \$486.00 85% = \$563.30	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with add or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated preparation, and excluding aftercare (not being a service associated with a s in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being photodynamic therapy with verteporfin) (Anaes.) (Assist.)	radiological services or service to which another item
35320	Fee: \$870.40 Benefit: 75% = \$652.80 85% = \$785.70	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for the treatment of uter fibroids or varicose veins) percutaneous or by open exposure, excluding associated radiological ser or preparation, and excluding aftercare, not being a service associated with photodynamic therapy verteporfin (Anaes.) (Assist.)	
35321	(See para TN.8.32 of explanatory notes to this Category) Fee: \$826.30 Benefit: 75% = \$619.75 85% = \$741.60	
	ANGIOSCOPY not combined with any other procedure, excluding associate preparation, and excluding aftercare (Anaes.) (Assist.)	ted radiological services or
35324	Fee: \$309.85 Benefit: 75% = \$232.40	
	ANGIOSCOPY combined with any other procedure, excluding associated a preparation, and excluding aftercare (Anaes.) (Assist.)	radiological services or
35327	Fee: \$415.25 Benefit: 75% = \$311.45	
	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by a associated radiological services or preparation, and excluding aftercare (An	
35330	Fee: \$523.60 Benefit: 75% = \$392.70 85% = \$445.10	
	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by including associated radiological services or preparation, and not including	
	Fee: \$601.95 Benefit: 75% = \$451.50	
35331		

T8. SUF	RGICAL OPERATIONS	3. VASCULAR		
	associated radiological services or preparation, and not including aftercare			
	(foreign body does not include an instrument inserted for the purpose of a service being (Anaes.) (Assist.)	rendered)		
	Fee: \$841.45 Benefit: 75% = \$631.10			
	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, not i associated radiological services or preparation, and not including aftercare	ncluding		
	(foreign body does not include an instrument inserted for the purpose of a service being (Anaes.) (Assist.)	rendered)		
35361	Fee: \$721.65 Benefit: 75% = \$541.25			
	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by not including associated radiological services or preparation, and not including aftercare			
	(foreign body does not include an instrument inserted for the purpose of a service being (Anaes.) (Assist.)	rendered)		
35362	Fee: \$601.95 Benefit: 75% = \$451.50			
	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percuta exposure, not including associated radiological services or preparation, and not includin			
	(foreign body does not include an instrument inserted for the purpose of a service being (Anaes.) (Assist.)	rendered)		
35363	Fee: \$482.25 Benefit: 75% = \$361.70			
	INTERVENTIONAL RADIOLOGY PROCEDURES			
	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective intern therapy of hepatic metastases which are secondary to colorectal cancer and are not suita or ablation, used in combination with systemic chemotherapy using 5-fluorouracil (5FU not being a service to which item 35317, 35319, 35320 or 35321 applies	ble for resection		
	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.			
35404	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$352.15 Benefit: 75% = \$264.15			
35406	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to embolis microvasculature of hepatic metastases which are secondary to colorectal cancer and are resection or ablation, for selective internal radiation therapy used in combination with sy chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which i 35319, 35320 or 35321 applies	e not suitable for ystemic		
55400				

T8. SUR	GICAL OPERATIONS	3. VASCULAR	
	excluding associated radiological services or preparation, and excluding	ng aftercare (Anaes.) (Assist.)	
	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$826.30 Benefit: 75% = \$619.75		
	Catheterisation of the hepatic artery via a permanently implanted hepa Spheres to embolise the microvasculature of hepatic metastases which and are not suitable for resection or ablation, for selective internal radi with systemic chemotherapy using 5-fluorouracil (5FU) and leucovori item 35317, 35319, 35320 or 35321 applies	are secondary to colorectal cancer iation therapy used in combination	
	excluding associated radiological services or preparation, and excluding	ng aftercare (Anaes.) (Assist.)	
35408	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$619.85 Benefit: 75% = \$464.90		
	UTERINE ARTERY CATHETERISATION with percutaneous admin the treatment of symptomatic uterine fibroids in a patient who has bee embolisation by a specialist gynaecologist, excluding associated radio excluding aftercare (Anaes.) (Assist.)	n referred for uterine artery	
35410	(See para TN.8.34 of explanatory notes to this Category) Fee: \$826.30 Benefit: 75% = \$619.75 85% = \$741.60		
	Intracranial aneurysm, ruptured or unruptured, endovascular occlusior assisted coiling if performed, with parent artery preservation, not for u including aftercare, including intra-operative imaging, but in associati operative diagnostic imaging items: - either 60009 or 60010; and	se with liquid embolics only,	
	- either 60072, 60073, 60075, 60076, 60078 or 60079 (Anaes.) (Assist.)		
35412	(See para TN.8.35 of explanatory notes to this Category) Fee: \$2,903.25 Benefit: 75% = \$2177.45 85% = \$2818.55		
	Mechanical thrombectomy, in a patient with a diagnosis of acute ischa of a large vessel of the anterior cerebral circulation, including intra-op		
	(a) the diagnosis is confirmed by an appropriate imaging modality suc magnetic resonance imaging or angiography; and	h as computed tomography,	
	(b) the service is performed by a specialist or consultant physician wit recognised by the Conjoint Committee for Recognition of Training in and		
	(c) the service is provided in an eligible stroke centre.		
	For any particular patient - applicable once per presentation by the patregardless of the number of times mechanical thrombectomy is attemp (Anaes.) (Assist.)		
35414	(See para TR.8.1 of explanatory notes to this Category) Fee: \$3,556.00 Benefit: 75% = \$2667.00		
T8. SUR	GICAL OPERATIONS	4. GYNAECOLOGICAL	
	Group T8. Surgical Operations		

T8. SUF	RGICAL OPERAT	IONS	4. GYNAECOLOGICAL
		Sut	bgroup 4. Gynaecological
		GICAL EXAMINATION U	UNDER ANAESTHESIA, not being a service associated with up applies (Anaes.)
35500	Fee: \$82.60	Benefit: 75% = \$61.95	5 85% = \$70.25
	ENDOMETRIA		TION OF, for the control of idiopathic menorrhagia, AND lometrial pathology, not being a service associated with a p applies (Anaes.)
35502	Fee: \$81.45	Benefit: 75% = \$61.10) 85% = \$69.25
			ction of, if the service is not associated with a service to which nan a service mentioned in item 30062) (Anaes.)
35503	Fee: \$54.40	Benefit: 75% = \$40.80) 85% = \$46.25
		A, not being a service assoc	EVICE, REMOVAL OF UNDER GENERAL ciated with a service to which another item in this Group
35506	Fee: \$54.55	Benefit: 75% = \$40.95	5 85% = \$46.40
	nerve block (exc	eluding pudendal block) rec 45 minutes - not being a se	val of under general anaesthesia, or under regional or field quiring admission to a hospital, where the time taken is less ervice associated with a service to which item 32177 or 32180
35507	Fee: \$177.25	Benefit: 75% = \$132.9	95 85% = \$150.70
	nerve block (exc	cluding pudendal block) rec ninutes - not being a servic	val of under general anaesthesia, or under regional or field quiring admission to a hospital, where the time taken is ce associated with a service to which item 32177 or 32180
35508	Fee: \$261.05	Benefit: 75% = \$195.8	30 85% = \$221.90
	HYMENECTO	MY (Anaes.)	
35509	Fee: \$90.90	Benefit: 75% = \$68.20) 85% = \$77.30
	BARTHOLIN'S	CYST, excision of (Anaes	s.)
35513	Fee: \$225.25	Benefit: 75% = \$168.9	95 85% = \$191.50
	BARTHOLIN'S	CYST OR GLAND, mars	supialisation of (Anaes.)
35517	Fee: \$148.35	Benefit: 75% = \$111.3	30 85% = \$126.10
	least 2cm in diar	meter in a postmenopausal	ts of at least 4cm in diameter in a premenopausal person and at person, by abdominal or vaginal route, using interventional h services provided for assisted reproductive techniques
35518	(See para TN.4.11 Fee: \$211.20	of explanatory notes to this C Benefit: 75% = \$158.4	
	BARTHOLIN'S	ABSCESS, incision of (Ar	.naes.)
	Fee: \$59.25	Benefit: 75% = \$44.45	

T8. SUF	RGICAL OPERATIONS	4. GYNAECOLOGICAL
	URETHRA OR URETHRAL CARUNCLE, cauterisation of (A	naes.)
35523	Fee: \$59.25 Benefit: 75% = \$44.45 85% = \$50.40	
	URETHRAL CARUNCLE, excision of (Anaes.)	
35527	Fee: \$148.35 Benefit: 75% = \$111.30 85% = \$126.10	
	CLITORIS, amputation of, where medically indicated (Anaes.)	(Assist.)
35530	Fee: \$274.15 Benefit: 75% = \$205.65	
	Vulvoplasty or labioplasty, for repair of:	
	(a) female genital mutilation; or	
	(b) an anomaly associated with a major congenital anomaly of the	ne uro-gynaecological tract
	other than a service associated with a service to which item 355. 43882 applies (Anaes.)	36, 37836, 37050, 37842, 37851 or
35533	(See para TN.8.123 of explanatory notes to this Category) Fee: \$355.45 Benefit: 75% = \$266.60	
Vulvoplasty or labioplasty, in a patient aged 18 years or more, performed by a special of the specialist's specialty, for a structural abnormality that is causing significant fur if the patient's labium extends more than 8 cm below the vaginal introitus while the p standing resting position (Anaes.)		ausing significant functional impairment,
35534	(See para TN.8.123 of explanatory notes to this Category) Fee: \$355.45 Benefit: 75% = \$266.60	
	VULVA, wide local excision of suspected malignancy or hemiv (Anaes.) (Assist.)	ulvectomy, 1 or both procedures
35536	Fee: \$354.05 Benefit: 75% = \$265.55 85% = \$300.95	
	COLPOSCOPICALLY DIRECTED CO ² LASER THERAPY for neoplastic changes of the cervix, vagina, vulva, urethra or anal c biopsies 1 anatomical site (Anaes.)	
35539	Fee: \$277.30 Benefit: 75% = \$208.00 85% = \$235.75	
	COLPOSCOPICALLY DIRECTED CO ² LASER THERAPY for neoplastic changes of the cervix, vagina, vulva, urethra or analo biopsies 2 or more anatomical sites (Anaes.) (Assist.)	
35542	Fee: \$324.70 Benefit: 75% = \$243.55 85% = \$276.00	
	COLPOSCOPICALLY DIRECTED CO ² LASER THERAPY for by other methods (Anaes.)	or condylomata, unsuccessfully treated
35545	Fee: \$186.55 Benefit: 75% = \$139.95 85% = \$158.60	
	VULVECTOMY, radical, for malignancy (Anaes.) (Assist.)	
35548	Fee: \$847.40 Benefit: 75% = \$635.55	
	PELVIC LYMPH NODES, excision of (radical) (Anaes.) (Assis	it.)
35551	Fee: \$694.85 Benefit: 75% = \$521.15	
35554	VAGINA, DILATATION OF, as an independent procedure incl	uding any associated consultation

10.001	GICAL OPERAT	IUNS	4. GYNAECOLOGICAL	
	(Anaes.)			
	Fee: \$44.20	Benefit: 75% = \$33.15 85% = \$37.60)	
	VAGINA, remov	val of simple tumour (including Gartner of	duct cyst) (Anaes.)	
35557	Fee: \$217.95	Benefit: 75% = \$163.50 85% = \$185	.30	
	VAGINA, partia	l or complete removal of (Anaes.) (Assis	t.)	
35560	Fee: \$694.85	Benefit: 75% = \$521.15		
	VAGINECTOM	Y, radical, for proven invasive malignan	cy - 1 surgeon (Anaes.) (Assist.)	
35561	Fee: \$1,401.55	Benefit: 75% = \$1051.20		
		Y, radical, for proven invasive malignan- are) (Anaes.) (Assist.)	cy, conjoint surgery - abdominal surgeon	
35562	Fee: \$1,150.70	Benefit: 75% = \$863.05		
	VAGINECTOM	Y, radical, for proven invasive malignan	cy, conjoint surgery - perineal surgeon (Assist.)	
35564	Fee: \$531.20	Benefit: 75% = \$398.40		
	VAGINAL REC (Assist.)	ONSTRUCTION for congenital absence	e, gynatresia or urogenital sinus (Anaes.)	
35565	Fee: \$694.85	Benefit: 75% = \$521.15		
	VAGINAL SEP	TUM, excision of, for correction of doub	le vagina (Anaes.) (Assist.)	
35566	Fee: \$403.60	Benefit: 75% = \$302.70		
	SACROSPINOU (Assist.)	JS COLPOPEXY FOR MANAGEMENT	Γ OF UPPER VAGINAL PROLAPSE (Anaes.)	
35568	Fee: \$634.60	Benefit: 75% = \$475.95		
	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes.)			
35569	Fee: \$163.40	Benefit: 75% = \$122.55		
	urethrocele and o		for pelvic organ prolapse (involving repair of aft, other than a service associated with a	
	(Anaes.) (Assis	t.)		
35570	Fee: \$562.70	Benefit: 75% = \$422.05		
	Posterior vagination one or more of the second seco		h for pelvic organ prolapse involving repair of	
	(a) perineum;			
	(b) rectocoele;			
	(c) enterocoele;			
35571			ociated with a service to which item 35573,	

T8. SUF	RGICAL OPERATIONS 4. GYNAECOLOGICAL
	(Anaes.) (Assist.)
	Fee: \$562.70 Benefit: 75% = \$422.05
	COLPOTOMY not being a service to which another item in this Group applies (Anaes.)
35572	Fee: \$125.80 Benefit: 75% = \$94.35
	Anterior and posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse (involving anterior and posterior compartment defects), using native tissue without graft, other than a service associated with a service to which item 35577 or 35578 applies.
	(Anaes.) (Assist.)
35573	Fee: \$844.20 Benefit: 75% = \$633.15
	Manchester (Donald Fothergill) operation for pelvic organ prolapse (includes cervical amputation, anterior and posterior native tissue vaginal wall repairs without graft).
	(Anaes.) (Assist.)
35577	Fee: \$685.30 Benefit: 75% = \$514.00
	LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.)
35578	Fee: \$685.30 Benefit: 75% = \$514.00
	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications, including graft related pain or discharge and bleeding related to graft exposure, less than 2cm^2 in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35582 or 35585 applies.
	(Anaes.) (Assist.)
35581	(See para TN.8.140 of explanatory notes to this Category) Fee: \$562.70 Benefit: 75% = \$422.05
	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications, including graft related pain or discharge and bleeding related to graft exposure, more than
	2cm ² in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35581 or 35585 applies.
	(Anaes.) (Assist.)
35582	(See para TN.8.140 of explanatory notes to this Category)Fee: $\$844.20$ Benefit: $75\% = \$633.15$
	Abdominal procedure either open, laparoscopic or robotic, for removal of graft material in patients symptomatic with graft related complications, including graft related pain or discharge and bleeding related to graft exposure or where the graft has penetrated adjacent organs such as the bladder (including urethra) or bowel, including retroperitoneal dissection and mobilisation of bladder and/or bowel, other than a service associated with a service to which item 35581 or 35582 applies.
35585	(Anaes.) (Assist.)

T8. SUF	RGICAL OPERATI	ONS	4. GYNAECOLOGICAL
	Fee: \$1,496.75	Benefit: 75% = \$1122.60	
	FIXATION OF T	HE UTEROSACRAL AND O	C FLOOR REPAIR INCORPORATING THE CARDINAL LIGAMENTS TO RECTOVAGINAL AND upper vaginal vault prolapse (Anaes.) (Assist.)
35595	Fee: \$1,173.50	Benefit: 75% = \$880.15	
		EEN GENITAL AND URINA 1 item 37029, 37333 or 37336	ARY OR ALIMENTARY TRACTS, repair of, not being applies (Anaes.) (Assist.)
35596	Fee: \$694.85	Benefit: 75% = \$521.15	
		partment and to sacrum for co	procedure where graft or mesh secured to vault, anterior prection of symptomatic upper vaginal vault prolapse
35597	Fee: \$1,496.75	Benefit: 75% = \$1122.60	
		TINENCE, sling operation for service to which item 30405 a	r, with or without mesh or tape, not being a service applies (Anaes.) (Assist.)
35599	Fee: \$685.30	Benefit: 75% = \$514.00	
	procedure, with o		onous ABDOMINOVAGINAL operation for; abdominal ercare), not being a service associated with a service to
35602	Fee: \$685.30	Benefit: 75% = \$514.00	
	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; procedure, with or without mesh, (including aftercare), not being a service associated with a s which item 30405 applies (Assist.)		
35605	Fee: \$371.80	Benefit: 75% = \$278.85 8	35% = \$316.05
		sation (other than by chemical of cervix (Anaes.)	l means), ionisation, diathermy or biopsy of, with or
35608	Fee: \$65.00	Benefit: 75% = \$48.75 85	j% = \$55.25
		al of polyp or polypi, with or v which item 35608 applies (An	without dilatation of cervix, not being a service associated aes.)
35611	Fee: \$65.00	Benefit: 75% = \$48.75 85	i% = \$55.25
	CERVIX, RESID	UAL STUMP, removal of, by	/ abdominal approach (Anaes.) (Assist.)
35612	Fee: \$514.10	Benefit: 75% = \$385.60 8	35% = \$437.00
			vaginal approach (Anaes.) (Assist.)
35613	Fee: \$411.30	Benefit: 75% = \$308.50	
	EXAMINATION abnormal cervical	OF LOWER TRACT by a Hi smear screen result or a histo	inselmanntype colposcope in a patient with a previous ory of maternal ingestion of oestrogen or where a patient, referred by another medical practitioner (Anaes.)
35614	(See para TN.8.42 o Fee: \$64.90	of explanatory notes to this Categorian Benefit: 75% = \$48.70 85	
35615	VULVA, biopsy o	of, when performed in conjunc	ction with a service to which item 35614 applies

T8. SUF	RGICAL OPERAT	IONS	4. GYNAECOLOGICAL	
	Fee: \$54.55	Benefit: 75% = \$40.95 85	5% = \$46.40	
			and ablation of, by microwave or thermal balloon or actory menorrhagia including any hysteroscopy erine curettage (Anaes.)	
35616	Fee: \$456.80	Benefit: 75% = \$342.60		
	CERVIX, cone l applies (Anaes.)	piopsy, amputation or repair of	, other than a service to which item 35577 or 35578	
35618	Fee: \$221.50	Benefit: 75% = \$166.15	35% = \$188.30	
		L BIOPSY where malignancy bleeding (Anaes.)	is suspected in patients with abnormal uterine bleeding or	
35620	Fee: \$54.20	Benefit: 75% = \$40.65 85	5% = \$46.10	
	including any hy		laser or diathermy, for chronic refractory menorrhagia ame day, with or without uterine curettage, not being a 30390 applies (Anaes.)	
35622	Fee: \$612.10	Benefit: 75% = \$459.10		
		PIC RESECTION of myoma, owed by endometrial ablation b	or myoma and uterine septum resection (where both are by laser or diathermy (Anaes.)	
35623	Fee: \$832.35	Benefit: 75% = \$624.30		
	where the patien	t is referred to him or her for the	ed by a specialist in the practice of his or her specialty ne investigation of suspected intrauterine pathology (with re associated with a service to which item 35627 or 35630	
35626	(See para TN.8.43 Fee: \$84.10	of explanatory notes to this Categ Benefit: 75% = \$63.10 8	-	
	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35630 applies (Anaes.)			
35627	Fee: \$108.85	Benefit: 75% = \$81.65		
			performed in the operating theatre of a hospital - not being m 35626 or 35627 applies (Anaes.)	
35630	Fee: \$185.95	Benefit: 75% = \$139.50		
	HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation (including finsertion of device for sterilisation) or removal of IUD which cannot be removed by other means more of (Anaes.)			
35633	Fee: \$221.50	Benefit: 75% = \$166.15	35% = \$188.30	
	HYSTEROSCO diathermy (Anac		eptum followed by endometrial ablation by laser or	
35634	Fee: \$696.65	Benefit: 75% = \$522.50	35% = \$611.95	
	HYSTEROSCO	PY involving resection of the	iterine septum (Anaes.)	
35635	Fee: \$304.25	Benefit: 75% = \$228.20		
35636			oma, or resection of myoma and uterine septum (where	

T8. SUF	RGICAL OPERATIONS	4. GYNAECOLOGICAL
	both are performed) (Anaes.)	
	Fee: \$439.95 Benefit: 75% = \$330.00	
	LAPAROSCOPY, involving puncture of cysts, diathermy of of adhesions or similar procedure - 1 or more procedures with associated with any other laparoscopic procedure or hysterect	n or without biopsy - not being a service
35637	(See para TN.1.4 of explanatory notes to this Category) Fee: \$413.15 Benefit: 75% = \$309.90	
	COMPLICATED OPERATIVE LAPAROSCOPY, including of the following procedures; oophorectomy, ovarian cystector salpingostomy, ablation of moderate or severe endometriosis or division of utero-sacral ligaments for significant dysmenor any other intraperitoneal or retroperitoneal procedure except i	my, myomectomy, salpingectomy or requiring more than 1 hours operating time, rhoea - not being a service associated with
35638	Fee: \$722.90 Benefit: 75% = \$542.20	
	UTERUS, CURETTAGE OF, with or without dilatation (incl miscarriage) under general anaesthesia, or under epidural or s procedures to which item 35626, 35627 or 35630 applies, if p	pinal (intrathecal) nerve block, including
35640	(See para TN.8.44 of explanatory notes to this Category) Fee: \$185.95 Benefit: 75% = \$139.50	
	ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RES following procedures, resection of the pelvic side wall includi tissue from the ureter, resection of the Pouch of Douglas, rese than 2 cms in diameter, dissection of bowel from uterus from above: where the operating time exceeds 90 minutes (Anaes.)	ing dissection of endometriosis or scar ection of an ovarian endometrioma greater the level of the endocervical junction or
35641	Fee: \$1,262.55 Benefit: 75% = \$946.95	
	EVACUATION OF THE CONTENTS OF THE GRAVID U CURETTAGE other than a service to which item 35640 appli 35626, 35627 or 35630 applies, if performed (Anaes.)	
35643	Fee: \$221.50 Benefit: 75% = \$166.15 85% = \$188.30	
	CERVIX, electrocoagulation diathermy with colposcopy, for neoplastic changes of the cervix, including any local anaesthe associated with a service to which item 35640 or 35647 applie	sia and biopsies, other than a service
35644	(See para TN.8.45 of explanatory notes to this Category) Fee: \$206.90 Benefit: 75% = \$155.20 85% = \$175.90	
	CERVIX, electrocoagulation diathermy with colposcopy, for neoplastic changes of the cervix, including any local anaesthe ablative therapy of additional areas of intraepithelial change i or anus, not being a service associated with a service to which	sia and biopsies, in conjunction with n 1 or more sites of vagina, vulva, urethra
35645	(See para TN.8.45 of explanatory notes to this Category) Fee: \$323.80 Benefit: 75% = \$242.85 85% = \$275.25	
	CERVIX, colposcopy with radical diathermy of, with or with confirmed intraepithelial neoplastic changes of the cervix (Ar	
35646	(See para TN.8.45 of explanatory notes to this Category) Fee: \$206.90 Benefit: 75% = \$155.20 85% = \$175.90	

T8. SUR	GICAL OPERATIONS	4. GYNAECOLOGICAL	
		n zone together with colposcopy for previously confirmed a, including any local anaesthesia and biopsies, not being a a 35644 applies (Anaes.)	
35647	(See para TN.8.45 of explanatory notes to this Cate Fee: \$206.90 Benefit: 75% = \$155.20		
	the cervix, including any local anaesthesia and	reviously confirmed intraepithelial neoplastic changes of l biopsies, in conjunction with ablative treatment of or more sites of vagina, vulva, urethra or anus, not being a n 35645 applies (Anaes.)	
35648	(See para TN.8.45 of explanatory notes to this Cate Fee: \$323.80 Benefit: 75% = \$242.85		
	HYSTEROTOMY or UTERINE MYOMECT	OMY, abdominal (Anaes.) (Assist.)	
35649	Fee: \$544.60 Benefit: 75% = \$408.45		
	HYSTERECTOMY, ABDOMINAL, SUBTO adnexae (Anaes.) (Assist.)	TAL or TOTAL, with or without removal of uterine	
35653	Fee: \$685.50 Benefit: 75% = \$514.15		
	 HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State 		
	and Territory law. Observe the explanatory n	ote before submitting a claim. (Anaes.) (Assist.)	
35657	(See para TN.8.46 of explanatory notes to this Cate Fee: \$685.50 Benefit: 75% = \$514.15	gory)	
	UTERUS (at least equivalent in size to a 10 w at hysterectomy (Anaes.) (Assist.)	eek gravid uterus), debulking of, prior to vaginal removal	
35658	(See para TN.8.47 of explanatory notes to this Cate Fee: \$422.70 Benefit: 75% = \$317.05	gory)	
		g extensive retroperitoneal dissection, with or without nent of severe endometriosis, pelvic inflammatory disease servation of the ovaries (Anaes.) (Assist.)	
35661	Fee: \$885.25 Benefit: 75% = \$663.95		
	uterine adnexae) for proven malignancy include	xcision of pelvic lymph nodes (with or without excision of ding excision of any 1 or more of parametrium, paracolpos, and involving ureterolysis where performed (Anaes.)	
35664	E oo: $\$1 475 45$ B onofit: $750/ - \$1106 60$		
5500+	Fee: \$1,475.45 Benefit: 75% = \$1106.60		
5500+	RADICAL HYSTERECTOMY without gland for proven malignancy including excision of a	l dissection (with or without excision of uterine adnexae) ny 1 or more of parametrium, paracolpos, upper vagina or reterolysis where performed (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERATIO	NS	4. GYNAECOLOGICAL
	HYSTERECTOMY of uterine adnexae		xcision of pelvic lymph nodes, with or without removal
35670	Fee: \$1,032.55	Benefit: 75% = \$774.45	
		Y, VAGINAL (with or with an cyst, 1 or more, 1 or both	out uterine curettage) with salpingectomy, oophorectomy h sides (Anaes.) (Assist.)
35673	Fee: \$769.90	Benefit: 75% = \$577.45	
	ULTRASOUND G	UIDED NEEDLING and in	jection of ectopic pregnancy
35674	(See para TN.4.11 of Fee: \$211.20	explanatory notes to this Categ Benefit: 75% = \$158.40	
	ECTOPIC PREGN	ANCY, removal of (Anaes.)) (Assist.)
35677	Fee: \$544.60	Benefit: 75% = \$408.45	
	ECTOPIC PREGN	ANCY, laparoscopic remov	val of (Anaes.) (Assist.)
35678	Fee: \$656.60	Benefit: 75% = \$492.45	
	BICORNUATE UT	FERUS, plastic reconstruction	on for (Anaes.) (Assist.)
35680	Fee: \$591.35	Benefit: 75% = \$443.55	85% = \$506.65
			, as an independent procedure (Anaes.) (Assist.)
35684	Fee: \$478.70	Benefit: 75% = \$359.05	
	STERILISATION		ESECTION OF FALLOPIAN TUBES, via abdominal or my or any other method
	benefits are not pay	vable for services not render	tion to sterilisation procedures on minors. Medicare red in accordance with relevant Commonwealth and State ote before submitting a claim. (Anaes.) (Assist.)
35688	(See para TN.8.46 of Fee: \$403.60	explanatory notes to this Categ Benefit: 75% = \$302.70	gory)
	STERILISATION with Caesarean sec		FALLOPIAN TUBES, when performed in conjunction
	benefits are not pay	vable for services not render	tion to sterilisation procedures on minors. Medicare red in accordance with relevant Commonwealth and State e before submitting a claim. (Anaes.) (Assist.)
35691	(See para TN.8.46 of Fee: \$161.25	explanatory notes to this Categ Benefit: 75% = \$120.95	gory)
		lpingostomy, salpingolysis more procedures (Anaes.) (or tubal implantation into uterus), UNILATERAL or (Assist.)
35694	Fee: \$647.90	Benefit: 75% = \$485.95	
35697	MICROSURGICA	L TUBOPLASTY (salpingo	ostomy, salpingolysis or tubal implantation into uterus),

T8. SUF		ONS		4. GYNAECOLOGICAL
	UNILATERAL o	r BILATERAL, 1 or more proc	cedures (Anaes.) (Assist.)	
	Fee: \$961.35	Benefit: 75% = \$721.05		
	FALLOPIAN TU (Assist.)	BES, unilateral microsurgical a	anastomosis of, using operat	ting microscope (Anaes.)
35700	Fee: \$741.75	Benefit: 75% = \$556.35		
		ON OF FALLOPIAN TUBES service to which another item i		
35703	Fee: \$68.60	Benefit: 75% = \$51.45 85%	6 = \$58.35	
	RUBIN TEST FC	R PATENCY OF FALLOPIA	N TUBES (Anaes.)	
35706	Fee: \$68.60	Benefit: 75% = \$51.45 85%	6 = \$58.35	
	FALLOPIAN TU	BES, hydrotubation of, as a rep	petitive postoperative procee	dure (Anaes.)
35709	Fee: \$44.20	Benefit: 75% = \$33.15 85%	6 = \$37.60	
	FALLOPOSCOP (Assist.)	Y, unilateral or bilateral, includ	ling hysteroscopy and tubal	catheterization (Anaes.)
35710	Fee: \$470.70	Benefit: 75% = \$353.05		
	OOPHORECTON	involving OOPHORECTOMY AY, removal of OVARIAN, PA procedure, other than a service	ARAOVARIAN, FIMBRIA	L or BROAD LIGAMENT
35713	Fee: \$460.10	Benefit: 75% = \$345.10		
	OOPHORECTON	involving OOPHORECTOM MY, removal of OVARIAN, PA e such procedures, unilateral or aes.) (Assist.)	ARAOVARIAN, FIMBRIA	L or BROAD LIGAMENT
35717	Fee: \$554.00	Benefit: 75% = \$415.50		
	RADICAL OR D omentectomy (An	EBULKING OPERATION for naes.) (Assist.)	advanced gynaecological n	nalignancy, with or without
35720	(See para TN.8.57 c Fee: \$685.30	of explanatory notes to this Catego Benefit: 75% = \$514.00	ry)	
		NEAL LYMPH NODE BIOPS		the aortic bifurcation, for
35723	Fee: \$490.85	Benefit: 75% = \$368.15		
		MENTECTOMY with multiple alignancy (Anaes.) (Assist.)	e peritoneal biopsies for stag	ging or restaging of
35726	Fee: \$490.85	Benefit: 75% = \$368.15		
	OVARIAN TRAN malignancy (Anae	NSPOSITION out of the pelvis es.)	, in conjunction with radical	l hysterectomy for invasive
35729	Fee: \$221.30	Benefit: 75% = \$166.00		
35730		ning for one or both ovaries to n the treatment volume and dos		

	RGICAL OPERATIO	- NS 4. G	YNAECOLOGICAL
	infertility (Anaes.)		
	Fee: \$221.30	Benefit: 75% = \$166.00	
	LAPAROSCOPIC. (Anaes.) (Assist.)	ALLY ASSISTED HYSTERECTOMY, including any associate	ed laparoscopy
35750	Fee: \$797.15	Benefit: 75% = \$597.90	
	procedures: salpin	ALLY ASSISTED HYSTERECTOMY with one or more of the gectomy, oophorectomy, excision of ovarian cyst or treatment of or both sides, including any associated laparoscopy (Anaes.) (A	of moderate
35753	Fee: \$881.50	Benefit: 75% = \$661.15	
	or other pathology, when performed w	ALLY ASSISTED HYSTERECTOMY which requires dissection, from the ureter, one or both sides, including any associated laps ith one or more of the following procedures: salpingectomy, oo treatment of endometriosis, not being a service to which item 35	aroscopy, including phorectomy, excision
35754	Fee: \$1,109.35	Benefit: 75% = \$832.05	
		ALLY ASSISTED HYSTERECTOMY, when procedure is comuding any associated laparoscopy (Anaes.) (Assist.)	pleted by open
35756	Fee: \$797.15	Benefit: 75% = \$597.90	
	under general anae	control of POST OPERATIVE HAEMORRHAGE following gyr esthesia, utilising a vaginal or abdominal and vaginal approach w rmed (Anaes.) (Assist.)	
35759	Fee: \$572.30	Benefit: 75% = \$429.25	
T8. SUF	RGICAL OPERATIO	INS	5. UROLOGICAL
	Group T8. Surgica	al Operations	
		Subgroup 5. Urological	
		GENERAL	
		GENERAL	
	PELVIC LYMPHA (Assist.)	ADENECTOMY, open or laparoscopic, or both, unilateral or bil	ateral (Anaes.)
36502			ateral (Anaes.)
36502	(Assist.) Fee: \$694.85	ADENECTOMY, open or laparoscopic, or both, unilateral or bil	
36502 36503	(Assist.) Fee: \$694.85	ADENECTOMY, open or laparoscopic, or both, unilateral or bil Benefit: 75% = \$521.15	
	(Assist.) Fee: \$694.85 RENAL TRANSPI Fee: \$1,413.40 RENAL TRANSPI	ADENECTOMY, open or laparoscopic, or both, unilateral or bil Benefit: 75% = \$521.15 LANT (not being a service to which item 36506 or 36509 applie	es) (Anaes.) (Assist.)
	(Assist.) Fee: \$694.85 RENAL TRANSPI Fee: \$1,413.40 RENAL TRANSPI	ADENECTOMY, open or laparoscopic, or both, unilateral or bil Benefit: 75% = \$521.15 LANT (not being a service to which item 36506 or 36509 applie Benefit: 75% = \$1060.05 LANT, performed by vascular surgeon and urologist operating to	es) (Anaes.) (Assist.)
36503	 (Assist.) Fee: \$694.85 RENAL TRANSPI Fee: \$1,413.40 RENAL TRANSPI anastomosis includ Fee: \$939.50 RENAL TRANSPI 	ADENECTOMY, open or laparoscopic, or both, unilateral or bil Benefit: 75% = \$521.15 LANT (not being a service to which item 36506 or 36509 applie Benefit: 75% = \$1060.05 LANT, performed by vascular surgeon and urologist operating to ling aftercare (Anaes.) (Assist.)	es) (Anaes.) (Assist.)

T8. SUF	GICAL OPERATIO	ONS 5. UROLOGICAL
	NEPHRECTOMY	7, complete (Anaes.) (Assist.)
36516	Fee: \$939.50	Benefit: 75% = \$704.65
	NEPHRECTOMY	<i>(</i> , complete, complicated by previous surgery on the same kidney (Anaes.) (Assist.)
36519	Fee: \$1,311.75	Benefit: 75% = \$983.85
	NEPHRECTOMY	(, partial (Anaes.) (Assist.)
36522	Fee: \$1,125.70	Benefit: 75% = \$844.30
	NEPHRECTOMY	<i>I</i> , partial, complicated by previous surgery on the same kidney (Anaes.) (Assist.)
36525	Fee: \$1,599.65	Benefit: 75% = \$1199.75
	tumour less than 1	<i>X</i> , radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a .0cms in diameter, where performed if malignancy is clinically suspected but not opathological examination (Anaes.) (Assist.)
36526	(See para TN.8.48 o Fee: \$1,311.75	of explanatory notes to this Category) Benefit: 75% = \$983.85 85% = \$1227.05
	tumour 10cms or a same kidney, whe	<i>X</i> , radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a more in diameter, or complicated by previous open or laparoscopic surgery on the re performed if malignancy is clinically suspected but not confirmed by examination (Anaes.) (Assist.)
36527	(See para TN.8.48 o Fee: \$1,618.90	of explanatory notes to this Category) Benefit: 75% = \$1214.20 85% = \$1534.20
		<i>I</i> , radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a 0 cms in diameter (Anaes.) (Assist.)
36528	Fee: \$1,311.75	Benefit: 75% = \$983.85
		<i>(</i> , radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a more in diameter, or complicated by previous open or laparoscopic surgery on the les.) (Assist.)
36529	Fee: \$1,618.90	Benefit: 75% = \$1214.20
		RECTOMY, complete, including associated bladder repair and any associated dures (Anaes.) (Assist.)
36531	Fee: \$1,176.40	Benefit: 75% = \$882.30
		ERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including repair and any associated endoscopic procedures (Anaes.) (Assist.)
36532	Fee: \$1,688.45	Benefit: 75% = \$1266.35
	associated bladder	ERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including r repair and any associated endoscopic procedures, complicated by previous open or ery on the same kidney or ureter (Anaes.) (Assist.)
36533	Fee: \$1,995.60	Benefit: 75% = \$1496.70
		RINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open a service to which another item in this Sub-group applies (Anaes.) (Assist.)
	1	

T8. SUF	GICAL OPERATIO	NS	5.	UROLOGICAL
	NEPHROLITHOT stones (Anaes.) (As		DTOMY, or both, through the same skin inci	sion, for 1 or 2
36540	Fee: \$1,125.70	Benefit: 75% = \$844.30	85% = \$1041.00	
	stones, including 1		DTOMY, or both, extended, for staghorn sto : nephrostomy, pyelostomy, pedicle control s.) (Assist.)	
36543	Fee: \$1,311.75	Benefit: 75% = \$983.85	85% = \$1227.05	
		EAL SHOCK WAVE LIT g pretreatment consultation	THOTRIPSY (ESWL) to urinary tract and po on, unilateral (Anaes.)	osttreatment care
36546	Fee: \$702.45	Benefit: 75% = \$526.85	85% = \$617.75	
	URETEROLITHO	TOMY (Anaes.) (Assist.))	
36549	Fee: \$846.45	Benefit: 75% = \$634.85		
	NEPHROSTOMY	or pyelostomy, open, as a	an independent procedure (Anaes.) (Assist.)	
36552	Fee: \$753.35	Benefit: 75% = \$565.05		
	RENAL CYST OR	CYSTS, excision or unro	oofing of (Anaes.) (Assist.)	
36558	Fee: \$660.20	Benefit: 75% = \$495.15	85% = \$575.50	
	RENAL BIOPSY (
36561	Fee: \$175.25	Benefit: 75% = \$131.45	85% = \$149.00	
	PYELOPLASTY,		the pelvi-ureteric junction) by open exposur	e, laparoscopy
36564	Fee: \$939.50	Benefit: 75% = \$704.65		
			tally abnormal in addition to the presence of exposure (Anaes.) (Assist.)	f PUJ
36567	Fee: \$1,032.55	Benefit: 75% = \$774.45		
	PYELOPLASTY, ((Assist.)	complicated by previous s	surgery on the same kidney, by open exposu	re (Anaes.)
36570	Fee: \$1,311.75	Benefit: 75% = \$983.85		
	DIVIDED URETE	R, repair of (Anaes.) (Ass	sist.)	
36573	Fee: \$939.50	Benefit: 75% = \$704.65		
	· •	. .	uding repair or nephrectomy, for trauma, not ned on the kidney, renal pelvis or renal pedic	0
36576	Fee: \$1,176.40	Benefit: 75% = \$882.30		
			TIAL, with or without associated bladder re em 37000 applies (Anaes.) (Assist.)	pair, not being a
36579	Fee: \$753.35	Benefit: 75% = \$565.05		
36585	URETER, transpla	ntation of, into skin (Anae	es.) (Assist.)	

T8. SUF	GICAL OPERAT	IONS 5. UROLOGIC		
	Fee: \$753.35	Benefit: 75% = \$565.05		
	URETER, reimpl	lantation into bladder (Anaes.) (Assist.)		
36588	Fee: \$939.50	Benefit: 75% = \$704.65		
	URETER, reimp	lantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.)		
36591	Fee: \$1,125.70	Benefit: 75% = \$844.30		
		lantation of, into intestine (Anaes.) (Assist.)		
36594	Fee: \$939.50	Benefit: 75% = \$704.65		
50571	-	lantation of, into another ureter (Anaes.) (Assist.)		
36597	Fee: \$939.50	Benefit: 75% = \$704.65		
30397		lantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.)		
26600	-	-		
36600	Fee: \$1,125.70	Benefit: 75% = \$844.30 85% = \$1041.00 plantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.)		
		• • • • • • •		
36603	Fee: \$1,311.75	Benefit: 75% = \$983.85		
	URETERIC STE techniques (Anae	NT, passage of through percutaneous nephrostomy tube, using interventional imaging es.)		
36604	Fee: \$271.95	Benefit: 75% = \$204.00 85% = \$231.20		
	URETERIC STENT, insertion of, with removal of calculus from:			
	(a) the pelvicalyceal system; or			
	(b) ureter; or			
	(c) the pelvicalyceal system and ureter;			
	through a nephro	stomy tube using interventional imaging techniques (Anaes.)		
36605	Fee: \$701.75	Benefit: 75% = \$526.35		
		RINARY RESERVOIR, continent, formation of, including formation of nonreturn ntation of ureters (1 or both) into reservoir (Anaes.) (Assist.)		
36606	Fee: \$2,352.85	Benefit: 75% = \$1764.65		
	URETERIC STE	NT insertion of, with baloon dilatation of:		
	(a) the pelvicalyceal system; or			
	(b) ureter; or			
	(c) the pelvicalyceal system and ureter;			
	through a nephro	stomy tube using interventional imaging techniques (Anaes.)		
36607	Fee: \$701.75	Benefit: 75% = \$526.35		
36600		NT, exchange of, percutaneously through either the ileal conduit or bladder, using aging techniques, not being a service associated with a service to which items 36811.		
36608		aging techniques, not being a service associated with a service to which items 3681		

T8. SUF	RGICAL OPERAT	ONS 5. UROLOGICA
	36854 apply (An	ies.)
	Fee: \$271.95	Benefit: 75% = \$204.00
	INTESTINAL U	RINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.)
36609	Fee: \$753.35	Benefit: 75% = \$565.05
	URETER, explor	ation of, with or without drainage of, as an independent procedure (Anaes.) (Assist.)
36612	Fee: \$660.20	Benefit: 75% = \$495.15
	either radiologica	S, with or without repositioning of the ureter, for obstruction of the ureter, evident lly or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis on (Anaes.) (Assist.)
36615	Fee: \$753.35	Benefit: 75% = \$565.05
	REDUCTION U	RETEROPLASTY (Anaes.) (Assist.)
36618	Fee: \$660.20	Benefit: 75% = \$495.15
	CLOSURE OF C	UTANEOUS URETEROSTOMY (Anaes.) (Assist.)
36621	Fee: \$471.95	Benefit: 75% = \$354.00
	NEPHROSTOM	Y, percutaneous, using interventional imaging techniques (Anaes.) (Assist.)
36624	Fee: \$567.05	Benefit: 75% = \$425.30 85% = \$482.35
		, percutaneous, with or without any 1 or more of; stone extraction, biopsy or ing a service to which item 36639, 36642, 36645 or 36648 applies (Anaes.)
36627	Fee: \$702.45	Benefit: 75% = \$526.85
	substantial portion	, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a n of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THI JE TO BLEEDING (Anaes.) (Assist.)
36630	Fee: \$346.95	Benefit: 75% = \$260.25
	ureter and includ	<i>Y</i> , percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ng antegrade insertion of ureteric stent, not being a service associated with a service to <i>Y</i> , 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.)
36633	Fee: \$753.35	Benefit: 75% = \$565.05 85% = \$668.65
	ureter and includ	<i>T</i> , percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ng antegrade insertion of ureteric stent, being a service associated with a service to <i>7</i> , 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.)
36636	Fee: \$406.30	Benefit: 75% = \$304.75
	NEPHROSCOPY, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (Anaes.)	
36639	Fee: \$846.45	Benefit: 75% = \$634.85
36642	substantial portion	Y, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a n of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THIJE TO BLEEDING (Anaes.) (Assist.)

T8. SUF	URGICAL OPERATIONS 5. UROLO		
	Fee: \$423.10	Benefit: 75% = \$317.35	
		Y, percutaneous, with removal or destru 3 or more stones (Anaes.) (Assist.)	ction of a stone greater than 3 cm in any
36645	Fee: \$1,083.35	Benefit: 75% = \$812.55	
		s been performed, IT IS NECESSARY	applies, WHERE, after a substantial portion of TO DISCONTINUE THE OPERATION
36648	Fee: \$964.80	Benefit: 75% = \$723.60	
	NEPHROSTOM	Y DRAINAGE TUBE, exchange of - b	ut not including imaging (Anaes.) (Assist.)
36649	Fee: \$271.95	Benefit: 75% = \$204.00 85% = \$23	1.20
			een stented with a double J ureteric stent and
36650	Fee: \$152.10	Benefit: 75% = \$114.10	
	ureteric meatotor		ith or without any one or more of, cystoscopy, ce associated with a service to which item
36652	Fee: \$660.20	Benefit: 75% = \$495.15	
	1 or more of extr pelvis or calyces,		
36654	Fee: \$846.45	Benefit: 75% = \$634.85	
	extraction of 2 or electrohydraulic fragments, not be	more stones in the renal pelvis or calycorn kinetic lithotripsy, or laser in the rena	ting a service to which item 36652 applies, plus tess or destruction of stone with ultrasound, al pelvis or calyces, with or without extraction of to which item 36654 applies to a procedure t.)
36656	Fee: \$1,083.35	Benefit: 75% = \$812.55	
		OPERATIONS ON	BLADDER
	catheterisation, w	vith biopsy of bladder, not being a servic 5508, 36812, 36830, 36836, 36840, 368	evulinate as an adjunct to white light, including ce associated with a service to which item 45, 36848, 36854, 37203, 37206, 37215, 37230
	(Anaes.)		
36504	(See para TN.8.2 o Fee: \$299.55	f explanatory notes to this Category) Benefit: 75% = \$224.70 85% = \$25%	4.65
26505	catheterisation, w	vith urethroscopy with or without urethr	evulinate as an adjunct to white light, including al dilatation, not being a service associated with urinary tract except a service to which item
36505			

T8. SUF	RGICAL OPERATIONS 5. UROLOGICA
	(Anaes.)
	(See para TN.8.2 of explanatory notes to this Category) Fee: \$235.40 Benefit: 75% = \$176.55 85% = \$200.10
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with resection, diathermy or visual laser destruction of bladder tumour or other lesion o the bladder, not being a service to which item 36840 or 36845 applies.
	(Anaes.)
36507	(See para TN.8.2 of explanatory notes to this Category) Fee: \$394.40 Benefit: 75% = \$295.80 85% = \$335.25
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter, not being a service to which item 36845 applies.
	(Anaes.)
36508	(See para TN.8.2 of explanatory notes to this Category) Fee: \$768.50 Benefit: 75% = \$576.40 85% = \$683.80
	Both:
	(a) percutaneous placement of sacral nerve lead or leads using fluoroscopic guidance, or open placement of sacral nerve lead or leads; and
	(b) intra-operative test stimulation, to manage:
	(i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or
	(ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment
	(Anaes.)
36663	Fee: \$671.55 Benefit: 75% = \$503.70 85% = \$586.85
	Both:
	(a) percutaneous repositioning of sacral nerve lead or leads using fluoroscopic guidance, or open repositioning of sacral nerve lead or leads; and
	(b) intra-operative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of:
	(i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or
	(ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment
36664	—other than a service to which item 36663 applies (Anaes.)

T8. SUF	RGICAL OPERAT	IONS		5. UROLOGICAL
	Fee: \$603.05	Benefit: 75% = \$452.30	85% = \$518.35	
			ement and adjustment of the pulse gen or non obstructive urinary retention -	
36665	Fee: \$127.40	Benefit: 75% = \$95.55	85% = \$108.30	
		subcutaneous placement of, trode or electrodes, for the r	and placement and connection of extended and placement of:	ension wire or wires to
	(a) detrusor over treatment; or	-activity that has been refrac	ctory to at least 12 months conservativ	ve non-surgical
	(b) non-obstructi non-surgical trea		s been refractory to at least 12 months	conservative
36666	Fee: \$339.35	Benefit: 75% = \$254.55	85% = \$288.45	
	Sacral nerve lead	l or leads, removal of, if the	lead was inserted to manage:	
	(a) detrusor over treatment; or	-activity that has been refrac	ctory to at least 12 months conservativ	ve non-surgical
	(b) non-obstructi non-surgical trea	•	s been refractory to at least 12 months	conservative
	(Anaes.)			
36667	Fee: \$158.80	Benefit: 75% = \$119.10	85% = \$135.00	
	Pulse generator,	removal of, if the pulse gene	erator was inserted to manage:	
	(a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or			
	(b) non-obstructi non-surgical trea	•	s been refractory to at least 12 months	s conservative
	(Anaes.)			
36668	Fee: \$158.80	Benefit: 75% = \$119.10	85% = \$135.00	
			treatment protocol, for the treatment	of overactive bladder,
	(a) the patient ha	s been diagnosed with idiop	pathic overactive bladder; and	
		s been refractory to, is contr ding anti-cholinergic agents	raindicated or otherwise not suitable f s); and	for conservative
	(c) the patient is therapy; and	contraindicated or otherwise	e not a suitable candidate for botulinu	m toxin type A
	(d) the patient is	contraindicated or otherwise	e not a suitable candidate for sacral ne	erve stimulation; and
36671	(e) the patient is	willing and able to comply	with the treatment protocol; and	

T8. SUF	GICAL OPERATIONS	5. UROLOGICAL
	(f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month per	iod; and
	(g) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts	for 30 minutes.
	For each patient—applicable only once, unless the patient achieves at least a 50% re overactive bladder symptoms from baseline at any time during the 3 month treatmer	
	Not applicable for a service associated with a service to which item 36672 or 36673	applies
	Fee: \$203.20 Benefit: 75% = \$152.40 85% = \$172.75	
	Percutaneous tibial nerve stimulation, tapering treatment protocol, for the treatment bladder, including any associated consultation at the time the percutaneous tibial ner treatment is administered, if:	
	(a) the patient responded to the percutaneous tibial nerve stimulation initial treatment achieved at least a 50% reduction in overactive bladder symptoms from baseline at a treatment period for the initial treatment protocol; and	
	(b) the tapering treatment protocol comprises no more than 5 sessions, delivered over and the interval between sessions is adjusted with the aim of sustaining therapeutic between treatment; and	
	(c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts	for 30 minutes.
	Not applicable for a service associated with a service to which item 36671 or 36673	applies
36672	Fee: \$203.20 Benefit: 75% = \$152.40 85% = \$172.75	
30072	Percutaneous tibial nerve stimulation, maintenance treatment protocol, for the treatment bladder, including any associated consultation at the time the percutaneous tibial ner treatment is administered, if:	
	(a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and to the tapering treatment protocol, and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and(b) the maintenance treatment protocol comprises no more than 12 sessions, delivered over a 12 month period, and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of the treatment; and	
	(c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts	for 30 minutes.
	Not applicable for service associated with a service to which item 36671 or 36672 a	pplies
36673	Fee: \$203.20 Benefit: 75% = \$152.40 85% = \$172.75	
	BLADDER, catheterisation of, where no other procedure is performed (Anaes.)	
36800	Fee: \$28.05 Benefit: 75% = \$21.05 85% = \$23.85	
36803	URETEROSCOPY, of one ureter, with or without any one or more of; cystoscopy, u	reteric meatotomy

T8. SUF	RGICAL OPERA	TIONS	5. UROLOGICAL
		ation, not being a service associated with a s 36809, 36812, 36824, 36848 or 36857 appli	
	(See para TN.8.5 Fee: \$473.80	1 of explanatory notes to this Category) Benefit: 75% = \$355.35 85% = \$402.75	5
	or ureteric dilat the ureter, not b service associat	DPY, of one ureter, with or without any one of ation, plus one or more of extraction of stone being a service associated with a service to with a service to which item 36809, 3682 ne same ureter (Anaes.) (Assist.)	e from the ureter, or biopsy or diathermy of which item 36803 or 36812 applies, or a
36806	Fee: \$660.20	Benefit: 75% = \$495.15	
	or ureteric dilat lithotripsy, or la to which item 3		er with ultrasound, electrohydraulic or kinetic , not being a service associated with a service ed with a service to which item 36806,
36809	Fee: \$846.45	Benefit: 75% = \$634.85	
1	CYSTOSCOPY	Y with insertion of urethral prosthesis (Anaes	s.)
36811	Fee: \$328.55	Benefit: 75% = \$246.45 85% = \$279.30	0
			dilatation, not being a service associated er urinary tract except a service to which item
36812	Fee: \$169.35	Benefit: 75% = \$127.05 85% = \$143.95	5
		<i>X</i> , with or without urethroscopy, for the treat associated with a service to which item 3018	
36815	(See para TN.8.9 Fee: \$241.70	of explanatory notes to this Category) Benefit: 75% = \$181.30 85% = \$205.45	5
			roscopic imaging of the upper urinary tract, service to which item 36824 or 36830 applies
36818	Fee: \$281.05	Benefit: 75% = \$210.80 85% = \$238.90	0
	CYSTOSCOPY with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral, not being a service associated with a service to which item 36824 of 36830 applies (Anaes.) (Assist.)		1.
36821	Fee: \$328.35	Benefit: 75% = \$246.30 85% = \$279.10	0
		Y, with ureteric catheterisation, unilateral or ich item 36818 or 36821 applies (Anaes.)	bilateral, not being a service associated with
1	Fee: \$216.55		
36824		Benefit: 75% = \$162.45 85% = \$184.10	0
36824	CYSTOSCOPY removal or repl	Benefit: $75\% = \$162.45$ $85\% = \$184.10$ <i>Y</i> , with endoscopic incision of pelviureteric j acement of ureteric stent, not being a service 36824, 36830 or 36833 applies (Anaes.) (As	unction or ureteric stricture, including e associated with a service to which item

T8. SUF	RGICAL OPERAT	IONS 5. UROLOGICAL
	CYSTOSCOPY	, with controlled hydrodilatation of the bladder (Anaes.)
36827	Fee: \$233.55	Benefit: 75% = \$175.20 85% = \$198.55
	CYSTOSCOPY	, with ureteric meatotomy (Anaes.)
36830	Fee: \$206.50	Benefit: 75% = \$154.90
	CYSTOSCOPY	, with removal of ureteric stent or other foreign body (Anaes.) (Assist.)
36833	Fee: \$281.05	Benefit: 75% = \$210.80 85% = \$238.90
		, with biopsy of bladder, not being a service associated with a service to which item 6840, 36845, 36848, 36854, 37203, 37206, 37215, 37230 or 37233 applies (Anaes.)
36836	(See para TN.8.2) Fee: \$233.55	of explanatory notes to this Category) Benefit: 75% = \$175.20 85% = \$198.55
		, with resection, diathermy or visual laser destruction of bladder tumour or other lesion ot being a service to which item 36845 applies (Anaes.)
36840	Fee: \$328.35	Benefit: 75% = \$246.30 85% = \$279.10
	or bladder and n	, with lavage of blood clots from bladder including any associated diathermy of prostate ot being a service associated with a service to which item 36812, 36827 to 36863, 37203 (Anaes.) (Assist.)
36842	Fee: \$330.40	Benefit: 75% = \$247.80
		, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 bladder or solitary tumour greater than 2cm in diameter (Anaes.)
36845	Fee: \$702.45	Benefit: 75% = \$526.85 85% = \$617.75
	CYSTOSCOPY	, with resection of ureterocele (Anaes.)
36848	Fee: \$233.55	Benefit: 75% = \$175.20
		h injection into bladder wall, other than a service associated with a service to which item applies (H) (Anaes.)
36851	Fee: \$233.55	Benefit: 75% = \$175.20
	CYSTOSCOPY (Anaes.)	, with endoscopic incision or resection of external sphincter, bladder neck or both
36854	Fee: \$473.80	Benefit: 75% = \$355.35
	ENDOSCOPIC	MANIPULATION OR EXTRACTION of ureteric calculus (Anaes.)
36857	Fee: \$372.30	Benefit: 75% = \$279.25
	ENDOSCOPIC	EXAMINATION of intestinal conduit or reservoir (Anaes.)
36860	Fee: \$169.35	Benefit: 75% = \$127.05 85% = \$143.95
	LITHOLAPAX	Y, with or without cystoscopy (Anaes.) (Assist.)
36863	Fee: \$473.80	Benefit: 75% = \$355.35
	BLADDER, par	tial excision of (Anaes.) (Assist.)
37000	Fee: \$753.35	Benefit: 75% = \$565.05

T8. SUF	RGICAL OPERAT	IONS 5. UROLOGIC	CAL
	BLADDER, rep	ir of rupture (Anaes.) (Assist.)	
37004	Fee: \$660.20	Benefit: 75% = \$495.15	
		OR CYSTOTOMY, suprapubic, not being a service to which item 37011 applies an ce associated with other open bladder procedure (Anaes.)	ıd
37008	Fee: \$423.10	Benefit: 75% = \$317.35 85% = \$359.65	
	SUPRAPUBIC 37200 to 37221	TAB CYSTOTOMY, not being a service associated with a service to which items apply (Anaes.)	
37011	Fee: \$94.85	Benefit: 75% = \$71.15 85% = \$80.65	
	BLADDER, tota	excision of (Anaes.) (Assist.)	
37014	Fee: \$1,083.35	Benefit: 75% = \$812.55	
	BLADDER DIV	ERTICULUM, excision or obliteration of (Anaes.) (Assist.)	
37020	Fee: \$753.35	Benefit: 75% = \$565.05	
	VESICAL FIST	JLA, cutaneous, operation for (Anaes.)	
37023	Fee: \$423.10	Benefit: 75% = \$317.35	
	-	/ESICOSTOMY, establishment of (Anaes.) (Assist.)	
37026	Fee: \$423.10	Benefit: 75% = \$317.35	
37020		AL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.)	
37029	Fee: \$939.50	Benefit: 75% = \$704.65	
37029		TINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.)	
27029		• · · · · · · · · ·	
37038	Fee: \$702.80	Benefit: 75% = \$527.10 continence, sling procedure for, using a non-adjustable synthetic male sling system,	
		nesh, other than a service associated with a service to which item 30405, 35599 or	
37040	Fee: \$925.90	Benefit: 75% = \$694.45	
	BLADDER ASI	IRATION by needle	
37041	Fee: \$47.35	Benefit: 75% = \$35.55 85% = \$40.25	
	harvesting of sli	ESS INCONTINENCE, sling procedure for, using autologous fascial sling, including, with or without mesh, not being a service associated with a service to which item applies (Anaes.) (Assist.)	
37042	Fee: \$925.90	Benefit: 75% = \$694.45	
		ESS INCONTINENCE, Stamey or similar type needle colposuspension, with or t being a service associated with a service to which item 30405 or 35599 applies	
37043	Fee: \$685.30	Benefit: 75% = \$514.00	
		ESS INCONTINENCE, suprapubic procedure for, eg Burch colposuspension, with out to being a service associated with a service to which item 30405 or 35599 applies	or
37044			

T8. SUF	GICAL OPERATIONS		5. UROLOGICAL	
	Fee: \$702.80	Benefit: 75% = \$527.10		
	CONTINENT C. (Assist.)	ATHETERISATION BLADDER S	TOMAS (eg. Mitrofanoff), formation of (Anaes.)	
37045	Fee: \$1,451.60	Benefit: 75% = \$1088.70		
	BLADDER ENI	LARGEMENT using intestine (Ana	es.) (Assist.)	
37047	Fee: \$1,692.70	Benefit: 75% = \$1269.55		
	BLADDER EXS	STROPHY CLOSURE, not involvin	ng sphincter reconstruction (Anaes.) (Assist.)	
37050	Fee: \$753.35	Benefit: 75% = \$565.05		
	BLADDER TRA	ANSECTION AND RE-ANASTON	IOSIS TO TRIGONE (Anaes.) (Assist.)	
37053	Fee: \$870.40	Benefit: 75% = \$652.80		
		OPERATIONS	ON PROSTATE	
	PROSTATECTO	OMY, open (Anaes.) (Assist.)		
37200	Fee: \$1,032.55	Benefit: 75% = \$774.45		
27201	medically fit for punch) and inclu or 37324 applies (See para TN.8.53	transurethral resection of the prosta adding services to which item 36854, s (Anaes.)	evere lower urinary tract symptoms who are not tte (that is, prostatectomy using diathermy or cold 37203, 37206, 37207, 37208, 37245, 37303, 37321	
37201	Fee: \$842.10	Benefit: 75% = \$631.60		
	without urethroso medically fit for punch) and inclu of, within 10 day	copy, in patients with moderate to s transurethral resection of the prosta uding services to which item 36854,	blation of, with or without cystoscopy and with or evere lower urinary tract symptoms who are not tte (that is prostatectomy using diathermy or cold 37245, 37303, 37321 or 37324 applies, continuation m 37201, 37203 or 37207 which had to be	
37202	(See para TN.8.53 Fee: \$422.70	of explanatory notes to this Category) Benefit: 75% = \$317.05 85% =	= \$359.30	
	or without urethr		or cold punch), with or without cystoscopy and with which item 36854, 37201, 37202, 37207, 37208,	
37203	Fee: \$1,058.80	Benefit: 75% = \$794.10		
	or without urethr continuation of,	roscopy, and including services to v	or cold punch), with or without cystoscopy and with which item 36854, 37303, 37321 or 37324 applies, cribed by item 37201, 37203, 37207 or 37245 which	
37206	Fee: \$567.05	Benefit: 75% = \$425.30		
	with or without u		isual laser ablation, with or without cystoscopy and	
	37206, 37245, 3	7321 or 37324 applies (Anaes.)	s to which items 36854, 37201, 37202, 37203,	

T8. SUF	RGICAL OPERATI	ONS	5. UROLOGICAL
	with or without un applies, continuat	oscopic non-contact (side firing) visual laser abla rethroscopy, and including services to which item ion of, within 10 days of the procedure described to be discontinued for medical reasons (Anaes.)	1 36854, 37303, 37321 or 37324
37208	Fee: \$422.70	Benefit: 75% = \$317.05	
		/or SEMINAL VESICLE/AMPULLA OF VAS, urvice associated with a service to which item num	
37209	Fee: \$1,311.75	Benefit: 75% = \$983.85	
	bladder and bladd	MY, radical, involving total excision of the prosta er neck reconstruction, not being a service associ 37375 applies (Anaes.) (Assist.)	
37210	Fee: \$1,618.90	Benefit: 75% = \$1214.20	
	bladder and bladd	MY, radical, involving total excision of the prostater neck reconstruction, <i>with pelvic lymphadenect</i> , which item 35551, 36502 or 37375 applies (Anaest	omy, not being a service associated
37211	Fee: \$1,966.15	Benefit: 75% = \$1474.65	
	PROSTATE, ope	n perineal biopsy or open drainage of abscess (Ar	naes.) (Assist.)
37212	Fee: \$281.05	Benefit: 75% = \$210.80	
	PROSTATE, bioj	osy of, endoscopic, with or without cystoscopy (A	Anaes.) (Assist.)
37215	Fee: \$423.10	Benefit: 75% = \$317.35 85% = \$359.65	
	Prostate, implanta (Anaes.)	tion of radio-opaque fiducial markers into the pro	ostate gland or prostate surgical bed
37217	(See para TN.8.54 o Fee: \$140.50	of explanatory notes to this Category) Benefit: 75% = \$105.40 85% = \$119.45	
	PROSTATE, nee	dle biopsy of, or injection into, excluding for inse	ertion of radiopaque markers (Anaes.)
37218	Fee: \$140.50	Benefit: 75% = \$105.40 85% = \$119.45	
		dle biopsy of, using prostatic ultrasound technique a service associated with a service to which item	
37219	Fee: \$285.35	Benefit: 75% = \$214.05 85% = \$242.55	
	guidance, for loca palpable or visible than or equal to 7 diagnosis. The pr radiation oncolog	oactive seed implantation of, urological compone lised prostatic malignancy at clinical stages T1 (c e by imaging) or T2 (tumour confined within pros and a prostate specific antigen (PSA) of less than rocedure must be performed by a urologist at an a ist, and be associated with a service to which item of explanatory notes to this Category)	clinically inapparent tumour not state), with a Gleason score of less n or equal to 10ng/ml at the time of pproved site in association with a
37220	Fee: \$1,060.90	Benefit: 75% = \$795.70	
	PROSTATIC AB	SCESS, endoscopic drainage of (Anaes.) (Assist.)
37221	Fee: \$473.80	Benefit: 75% = \$355.35	

10. 306	GICAL OPERAT	IONS	5. UROLOGICAL
	PROSTATIC CO	OIL, insertion of, under ultras	sound control (Anaes.)
37223	Fee: \$209.55	Benefit: 75% = \$157.20	
			action of lesion of, not being a service associated with a 37206, 37207, 37208 or 37215 applies (Anaes.)
37224	Fee: \$328.35	Benefit: 75% = \$246.30	85% = \$279.10
	guidance includi	ng any associated cystoscopy a radiation oncologist, and be	ters into, for high dose rate brachytherapy using ultrasound y. The procedure must be performed at an approved site in be associated with a service to which item 15331 or 15332
37227	(See para TN.8.56 Fee: \$574.90	of explanatory notes to this Cate Benefit: 75% = \$431.20	
	with or without u		owave thermotherapy of, with or without cystoscopy and ervices to which item 36854, 37203, 37206, 37207, 37208,
37230	Fee: \$1,058.80	Benefit: 75% = \$794.10	85% = \$974.10
	with or without u applies, continua	urethroscopy and including se	bwave thermotherapy of, with or without cystoscopy and ervices to which item 36854, 37303, 37321 or 37324 e procedure described by item 37201, 37203, 37207, 37230 sons (Anaes.)
37233	Fee: \$567.05	Benefit: 75% = \$425.30	85% = \$482.35
	contact fibre, with benign prostatic	th or without tissue morcellat hyperplasia, and other than a	gh powered Holmium:YAG laser and an end-firing, non- tion, cystoscopy or urethroscopy, for the treatment of a service associated with a service to which item 36854, 37303, 37321, or 37324 applies. (Anaes.)
37245	Fee: \$1,282.35	Benefit: 75% = \$961.80	
		OPERATIONS ON L	URETHRA, PENIS OR SCROTUM
	URETHRAL SC	UNDS, passage of, as an ind	dependent procedure (Anaes.)
37300	Fee: \$47.35	Benefit: 75% = \$35.55	85% = \$40.25
	URETHRAL ST	RICTURE, dilatation of (Ana	laes.)
37303	Fee: \$75.25	Benefit: 75% = \$56.45	85% = \$64.00
	URETHRA, repa	air of rupture of distal section	n (Anaes.) (Assist.)
37306	Fee: \$660.20	Benefit: 75% = \$495.15	
	URETHRA, repa	air of rupture of prostatic or n	membranous segment (Anaes.) (Assist.)
37309	Fee: \$939.50	Benefit: 75% = \$704.65	
	URETHROSCO	PY, as an independent procee	dure (Anaes.)
37315	Fee: \$140.50	Benefit: 75% = \$105.40	85% = \$119.45
		PPY with any 1 or more of - b gn body or stone (Anaes.) (As	biopsy, diathermy, visual laser destruction of stone or assist.)

T8. SUF	GICAL OPERATION	S	5. UROLOGICAL
	URETHRAL MEAT	OTOMY, EXTERNAL (Anaes.)	
37321	Fee: \$94.85	Benefit: 75% = \$71.15 85% = \$80.65	
	URETHROTOMY O	R URETHROSTOMY, internal or external (Anaes.)	
37324	Fee: \$233.55	Benefit: 75% = \$175.20	
	URETHROTOMY, o	ptical, for urethral stricture (Anaes.) (Assist.)	
37327	Fee: \$328.35	Benefit: 75% = \$246.30	
	URETHRECTOMY,	partial or complete, for removal of tumour (Anaes.)	(Assist.)
37330	Fee: \$660.20	Benefit: 75% = \$495.15	
	URETHROVAGINA	L FISTULA, closure of (Anaes.) (Assist.)	
37333	Fee: \$567.05	Benefit: 75% = \$425.30	
	URETHRORECTAL	FISTULA, closure of (Anaes.) (Assist.)	
37336	Fee: \$753.35	Benefit: 75% = \$565.05	
	following previous su	le sling system, division or removal of, for urethral o rgery for urinary incontinence, other than a service a 37341 applies (Anaes.) (Assist.)	
37338	Fee: \$925.90	Benefit: 75% = \$694.45	
		rethral injection of materials for the treatment of urin roscopy, other than a service associated with a servic a.)	
37339	Fee: \$243.70	Benefit: 75% = \$182.80 85% = \$207.15	
	surgery for urinary in	, division or removal of, for urethral obstruction or excontinence, vaginal approach, not being a service ass 7341 applies (Anaes.) (Assist.)	
37340	Fee: \$431.80	Benefit: 75% = \$323.85	
	surgery for urinary in	, division or removal of, for urethral obstruction or excontinence, suprapubic or combined suprapubic/vagith a service to which item number 37340 applies (An	inal approach, not being a
37341	Fee: \$925.90	Benefit: 75% = \$694.45	
	URETHROPLASTY	single stage operation (Anaes.) (Assist.)	
37342	Fee: \$846.45	Benefit: 75% = \$634.85	
	below the symphysis	, single stage operation, transpubic approach via sepa pubis, excluding laparotomy, symphysectomy and su the urethra around the crura (Anaes.) (Assist.)	
37343	Fee: \$1,413.40	Benefit: 75% = \$1060.05	
	URETHROPLASTY	2 stage operation first stage (Anaes.) (Assist.)	
37345	Fee: \$702.45	Benefit: 75% = \$526.85	
27240	URETHROPLASTY	2 stage operation second stage (Anaes.) (Assist.)	
37348			

T8. SUF		IONS 5. UROLOGICAL
	Fee: \$702.45	Benefit: 75% = \$526.85
	URETHROPLAS	STY, not being a service to which another item in this Group applies (Anaes.) (Assist.)
37351	Fee: \$281.05	Benefit: 75% = \$210.80
	HYPOSPADIAS	, meatotomy and hemicircumcision (Anaes.) (Assist.)
37354	Fee: \$328.35	Benefit: 75% = \$246.30
57551		ision of prolapse of (Anaes.)
37369	Fee: \$189.60	Benefit: 75% = \$142.20
37309		VERTICULUM, excision of (Anaes.) (Assist.)
07070		
37372	Fee: \$473.80	Benefit: 75% = \$355.35 HINCTER, reconstruction by bladder tubularisation technique or similar procedure
	(Anaes.) (Assist.)	•
37375	Fee: \$1,176.40	Benefit: 75% = \$882.30
	ARTIFICIAL UI	RINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.)
37381	Fee: \$753.35	Benefit: 75% = \$565.05
	ARTIFICIAL UI	RINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.)
37384	Fee: \$1,176.40	Benefit: 75% = \$882.30
		RINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.)
	(Assist.)	
37387	Fee: \$328.35	Benefit: 75% = \$246.30
	ARTIFICIAL UF (Assist.)	RINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.)
37390	Fee: \$939.50	Benefit: 75% = \$704.65
	PRIAPISM, deco without lavage (A	ompression by glanular stab cavernosospongiosum shunt or penile aspiration with or Anaes.)
37393	Fee: \$233.55	Benefit: 75% = \$175.20 85% = \$198.55
	PRIAPISM, shur	nt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.)
37396	Fee: \$753.35	Benefit: 75% = \$565.05
	PENIS, partial ar	nputation of (Anaes.) (Assist.)
37402	Fee: \$473.80	Benefit: 75% = \$355.35
	PENIS, complete	e or radical amputation of (Anaes.) (Assist.)
37405	Fee: \$939.50	Benefit: 75% = \$704.65
		laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.)
37408	Fee: \$473.80	Benefit: 75% = \$355.35
57700		avulsion (Anaes.) (Assist.)
27411	_	
37411	Fee: \$939.50	Benefit: 75% = \$704.65 85% = \$854.80

T8. SUF	RGICAL OPERATI	ONS	5. UROLOGICAL
	PENIS, injection of, for the investigation and treatment of impotence - 2 services on consecutive months		services only in a period of 36
37415	Fee: \$47.35	Benefit: 75% = \$35.55 85% = \$40.25	
	PENIS, correction grafting (Anaes.)	n of chordee, with or without excision of fibrous plaque (Assist.)	or plaques and with or without
37417	Fee: \$567.05	Benefit: 75% = \$425.30	
		n of chordee, with or without excision of fibrous plaque g mobilization of the urethra (Anaes.) (Assist.)	or plaques and with or without
37418	Fee: \$753.35	Benefit: 75% = \$565.05 85% = \$668.65	
		o inhibit rapid penile drainage causing impotence, by lig or more deep cavernosal veins with or without pharma	
37420	Fee: \$372.30	Benefit: 75% = \$279.25	
	PENIS, lengtheni	ng by translocation of corpora (Anaes.) (Assist.)	
37423	Fee: \$939.50	Benefit: 75% = \$704.65	
	PENIS, artificial	erection device, insertion of, into 1 or both corpora (An	aes.) (Assist.)
37426	Fee: \$990.15	Benefit: 75% = \$742.65	
57120		erection device, insertion of pump and pressure regulati	ng reservoir (Anaes.) (Assist.)
37429	Fee: \$328.35	Benefit: 75% = \$246.30	
	PENIS, artificial replacement (Ana	erection device, complete or partial revision or removal	of components, with or without
37432	Fee: \$939.50	Benefit: 75% = \$704.65	
	PENIS, frenulopl	asty as an independent procedure (Anaes.)	
37435	Fee: \$94.85	Benefit: 75% = \$71.15 85% = \$80.65	
		ial excision of (Anaes.) (Assist.)	
37438	Fee: \$281.05	Benefit: 75% = \$210.80 85% = \$238.90	
57450	Fee: \$281.05 Benefit: 75% = \$210.80 85% = \$238.90 URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes.) (Assist.)		
37444	Fee: \$1,015.65	Benefit: 75% = \$761.75 85% = \$930.95	
		OPERATIONS ON TESTES, VASA OR SEMINAL	VESICLES
	SPERMATOCEI	LE OR EPIDIDYMAL CYST, excision of, 1 or more of	, on 1 side (Anaes.)
37601	Fee: \$281.05	Benefit: 75% = \$210.80 85% = \$238.90	
	EXPLORATION	OF SCROTAL CONTENTS, with or without fixation ng a service associated with sperm harvesting for IVF (
37604	Fee: \$281.05	Benefit: 75% = \$210.80 85% = \$238.90	
37605	Transcutaneous s	perm retrieval, unilateral, from either the testis or the ep nic sperm injection, for male factor infertility, excluding	

T8. SUF		ONS	5. UROLOGICAL
	applies. (Anaes.)		
	(See para TN.8.58, Fee: \$379.45	TN.1.5 of explanatory notes to this Category) Benefit: 75% = \$284.60 85% = \$322.5	5
	biopsy, for the pu		loration of scrotal contents, with our without n, for male factor infertility, performed in a 4 applies. (Anaes.)
37606	(See para TN.1.5, T Fee: \$563.40	N.8.59 of explanatory notes to this Category) Benefit: 75% = \$422.55 85% = \$478.9	0
		NEAL LYMPH NODE DISSECTION, un tem 36528 applies (Anaes.) (Assist.)	ilateral, not being a service associated with a
37607	Fee: \$939.50	Benefit: 75% = \$704.65	
	service to which i	NEAL LYMPH NODE DISSECTION, un tem 36528 applies, following previous sir adiation or chemotherapy (Anaes.) (Assis	
37610	Fee: \$1,413.40	Benefit: 75% = \$1060.05	
	EPIDIDYMECTO	DMY (Anaes.)	
37613	Fee: \$281.05	Benefit: 75% = \$210.80 85% = \$238.9	0
		MY or VASOEPIDIDYMOSTOMY, un sociated with sperm harvesting for IVF (A	ilateral, using operating microscope, not
37616	Fee: \$702.45	Benefit: 75% = \$526.85	
		MY or VASOEPIDIDYMOSTOMY, unifor IVF (Anaes.) (Assist.)	ilateral, not being a service associated with
37619	Fee: \$281.05 Extended Medica	Benefit: 75% = \$210.80 85% = \$238.9 are Safety Net Cap: \$224.85	0
	VASOTOMY OR	VASECTOMY, unilateral or bilateral	
	benefits are not pe	al requirements apply in relation to steril ayable for services not rendered in accord . Observe the explanatory note before su	dance with relevant Commonwealth and State
37623	(See para TN.8.46 c Fee: \$233.55	of explanatory notes to this Category) Benefit: 75% = \$175.20 85% = \$198.5.	5
	PAEDIATRIC GENITURINARY SURGERY		
	PATENT URACI	HUS, excision of, on a person 10 years of	age or over. (Anaes.) (Assist.)
37800	Fee: \$529.60	Benefit: 75% = \$397.20	
			erson under 10 years of age (Anaes.) (Assist.)
37801	Fee: \$688.50	Benefit: 75% = \$516.40	
37803	UNDESCENDED	D TESTIS, orchidopexy for, not being a set f age or over. (Anaes.) (Assist.)	ervice to which item 37806 applies, on a

T8. SUF	RGICAL OPERAT	IONS 5. UROLOGICAL
	Fee: \$529.60	Benefit: 75% = \$397.20
		D TESTIS, orchidopexy for, not being a service to which item 37807 applies, on a years of age (Anaes.) (Assist.)
37804	Fee: \$688.50	Benefit: 75% = \$516.40
		D TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, on a person 10 years of age or over (Anaes.) (Assist.)
37806	Fee: \$611.90	Benefit: 75% = \$458.95 85% = \$527.20
		D TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, on a person under 10 years of age (Anaes.) (Assist.)
37807	Fee: \$795.50	Benefit: 75% = \$596.65 85% = \$710.80
	UNDESCENDE (Assist.)	D TESTIS, revision orchidopexy for, on a person 10 years of age or over. (Anaes.)
37809	Fee: \$611.90	Benefit: 75% = \$458.95
	UNDESCENDE (Assist.)	D TESTIS, revision orchidopexy for, on a person under 10 years of age (Anaes.)
37810	Fee: \$795.50	Benefit: 75% = \$596.65
		TESTIS, exploration of groin for, not being a service associated with a service to which 306 and 37809 applies, on a person 10 years of age or over. (Anaes.) (Assist.)
37812	Fee: \$564.90	Benefit: 75% = \$423.70
		TESTIS, exploration of groin for, not being a service associated with a service to which 307 and 37810 applies, on a person under 10 years of age (Anaes.) (Assist.)
37813	Fee: \$734.35	Benefit: 75% = \$550.80
	HYPOSPADIAS (Anaes.)	S, examination under anaesthesia with erection test on a person 10 years of age or over.
37815	Fee: \$94.25	Benefit: 75% = \$70.70
	HYPOSPADIAS (Anaes.)	s, examination under anaesthesia with erection test, on a person under 10 years of age
37816	Fee: \$122.55	Benefit: 75% = \$91.95
	HYPOSPADIAS (Anaes.) (Assist.	S, glanuloplasty incorporating meatal advancement, on a person 10 years of age or over)
37818	Fee: \$499.30	Benefit: 75% = \$374.50 85% = \$424.45
	HYPOSPADIAS (Anaes.) (Assist.	S, glanuloplasty incorporating meatal advancement, on a person under 10 years of age
37819	Fee: \$649.10	Benefit: 75% = \$486.85 85% = \$564.40
	HYPOSPADIAS	S, distal, 1 stage repair, on a person 10 years of age or over. (Anaes.) (Assist.)
37821	Fee: \$846.45	Benefit: 75% = \$634.85
		S, distal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.)
37822	Fee: \$1,100.40	Benefit: 75% = \$825.30
51022	1 cc. \$1,100.40	Denem: $1570 - 0023.30$

T8. SUF	RGICAL OPERAT	ONS 5. UROLOGICAL
	HYPOSPADIA	proximal, 1 stage repair on a person 10 years of age or over. (Anaes.) (Assist.)
37824	Fee: \$1,176.85	Benefit: 75% = \$882.65
	HYPOSPADIA	proximal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.)
37825	Fee: \$1,529.90	Benefit: 75% = \$1147.45
	HYPOSPADIA	staged repair, first stage, on a person 10 years of age or over. (Anaes.) (Assist.)
37827	Fee: \$542.15	Benefit: 75% = \$406.65
	HYPOSPADIA	staged repair, first stage, on a person under 10 years of age (Anaes.) (Assist.)
37828	Fee: \$704.80	Benefit: 75% = \$528.60
	HYPOSPADIA	staged repair, second stage, on a person 10 years of age or over. (Anaes.) (Assist.)
37830	Fee: \$702.45	Benefit: 75% = \$526.85 85% = \$617.75
	HYPOSPADIA	staged repair, second stage, on a person under 10 years of age. (Anaes.) (Assist.)
37831	Fee: \$913.30	Benefit: 75% = \$685.00 85% = \$828.60
	HYPOSPADIA (Assist.)	repair of post-operative urethral fistula, on a person 10 years of age or over. (Anaes.)
37833	Fee: \$335.25	Benefit: 75% = \$251.45
	HYPOSPADIA (Assist.)	repair of post-operative urethral fistula, on a person under 10 years of age (Anaes.)
37834	Fee: \$435.80	Benefit: 75% = \$326.85
	EPISPADIAS, s	aged repair, first stage (Anaes.) (Assist.)
37836	Fee: \$706.10	Benefit: 75% = \$529.60
	EPISPADIAS, s	aged repair, second stage (Anaes.) (Assist.)
37839	Fee: \$800.20	Benefit: 75% = \$600.15
		F BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with c reimplantation (Anaes.) (Assist.)
37842	Fee: \$1,553.55	Benefit: 75% = \$1165.20
	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes.) (Assist.)	
37845	Fee: \$706.10	Benefit: 75% = \$529.60
		ENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy (Anaes.) (Assist.)
37848	Fee: \$1,271.05	Benefit: 75% = \$953.30
		ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, with or without endoscopy (Anaes.) (Assist.)
37851	Fee: \$941.65	Benefit: 75% = \$706.25
37854	URETHRAL V.	LVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.)

T8. SUF	RGICAL OPERAT	IONS	5. UROLOGICAL
	Fee: \$372.30	Benefit: 75% = \$279.25	
T8. SUF	GICAL OPERAT	IONS	6. CARDIO-THORACIC
	Group T8. Surg	ical Operations	
		Subgrou	p 6. Cardio-Thoracic
		CARDIOLC	DGY PROCEDURES
			ny one or more of the following: fluoroscopy, oximetry, t by any method, shunt detection or exercise stress test
38200	Fee: \$452.55	Benefit: 75% = \$339.45 85	5% = \$384.70
	left ventricular p	uncture with any one or more o	taneous arterial puncture, arteriotomy or percutaneous of the following: fluoroscopy, oximetry, dye dilution thod, shunt detection or exercise stress test (Anaes.)
38203	Fee: \$540.05	Benefit: 75% = \$405.05 85	5% = \$459.05
	or by any other p	procedure with any one or more	LEFT HEART CATHETERISATION via the right heart of the following: fluoroscopy, oximetry, dye dilution thod, shunt detection or exercise stress test (Anaes.)
38206	Fee: \$652.95	Benefit: 75% = \$489.75 85	5% = \$568.25
	1 or more of syr	ncope, atrioventricular conduction	JDY up to and including 3 catheter investigation of any on, sinus node function or simple ventricular tachycardia rvice to which item 38212 or 38213 applies (Anaes.)
38209	(See para TN.8.60 Fee: \$838.35	of explanatory notes to this Catego Benefit: 75% = \$628.80 8:	
	 CARDIAC ELECTROPHYSIOLOGICAL STUDY 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation not being a service associated with a service to which item 38209 or 38213 applies (Anaes.) 		s, or multiple catheter mapping, or acute intravenous ug inductions; or catheter ablation to intentionally induce or electrophysiological services during defibrillator
38212	(See para TN.8.60 Fee: \$1,394.40	of explanatory notes to this Catego Benefit: 75% = \$1045.80	
		CTROPHYSIOLOGICAL STU	JDY, for follow-up testing of implanted defibrillator - not ch item 38209 or 38212 applies (Anaes.)
Benefit: 75% = \$311.45 85% = \$353.00		5% = \$353.00	
	into the native co	pronary arteries, not being a service	placement of catheters and injection of opaque material vice associated with a service to which item 38218, 237, 38240 or 38246 applies (Anaes.)
38215	(See para TN.8.52 Fee: \$360.60	of explanatory notes to this Catego Benefit: 75% = \$270.45 8	-
38218	with right or left	heart catheterisation or both, or	placement of catheters and injection of opaque material r aortography, not being a service associated with a 225, 38228, 38231, 38234, 38237, 38240 or 38246

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC
	applies (Anaes.)	
	(See para TN.8.52 of explanatory notes to this Category) Fee: \$540.75 Benefit: 75% = \$405.60 85% = \$459.65	
	SELECTIVE CORONARY GRAFT ANGIOGRAPHY place material into free coronary graft(s) attached to the aorta (irres a service associated with a service to which item 38215, 3821 38237, 38240 or 38246 applies (Anaes.)	pective of the number of grafts), not being
38220	(See para TN.8.52 of explanatory notes to this Category) Fee: \$180.25 Benefit: 75% = \$135.20 85% = \$153.25	
	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, place opaque material into direct internal mammary artery graft(s) t (irrespective of the number of grafts), not being a service asso 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or	to one or more coronary arteries ociated with a service to which item 38215,
38222	(See para TN.8.52 of explanatory notes to this Category) Fee: \$360.60 Benefit: 75% = \$270.45 85% = \$306.55	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of into the native coronary arteries and placement of catheter(s) coronary graft(s) attached to the aorta (irrespective of the nun associated with a service to which item 38215, 38218, 38220, 38240 or 38246 applies (Anaes.)	and injection of opaque material into free nber of grafts), not being a service
38225	(See para TN.8.52 of explanatory notes to this Category) Fee: \$540.85 Benefit: 75% = \$405.65 85% = \$459.75	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of into the native coronary arteries and placement of catheter(s) internal mammary artery graft(s) to one or more coronary arter not being a service associated with a service to which item 38 38234, 38237, 38240 or 38246 applies (Anaes.)	and injection of opaque material into direct eries (irrespective of the number of grafts),
38228	(See para TN.8.52 of explanatory notes to this Category) Fee: \$721.25 Benefit: 75% = \$540.95 85% = \$636.55	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of into the native coronary arteries and placement of catheter(s) free coronary graft(s) attached to the aorta (irrespective of the catheter(s) and injection of opaque material into direct interna coronary arteries (irrespective of the number of grafts), not be which item 38215, 38218, 38220, 38222, 38225, 38228, 3823	and injection of opaque material into the e number of grafts), and placement of al mammary artery graft(s) to one or more eing a service associated with a service to
38231	(See para TN.8.52 of explanatory notes to this Category) Fee: \$901.45 Benefit: 75% = \$676.10 85% = \$816.75	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of with right or left heart catheterisation or both, or aortography of opaque material into free coronary graft(s) attached to the a not being a service associated with a service to which item 38 38231, 38237, 38240 or 38246 applies (Anaes.)	and placement of catheter(s) and injection aorta (irrespective of the number of grafts),
38234	(See para TN.8.52 of explanatory notes to this Category) Fee: \$721.10 Benefit: 75% = \$540.85 85% = \$636.40	
38237	SELECTIVE CORONARY ANGIOGRAPHY, placement of with right or left heart catheterisation or both, or aortography	v 11

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC
	of opaque material into direct internal mammary artery graft(s) (irrespective of the number of grafts), not being a service associate 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38228, 38231, 38234, 38240 or 38234, 38240 or 38234, 38234, 38240 or 38234, 38234, 38240 or 38234, 38234, 38234, 38240 or 38234, 38240, 382400, 382400, 382400, 382400, 382400, 382400, 3824000, 3824000000000000000000000000000000000000	tiated with a service to which item 38215,
	(See para TN.8.52 of explanatory notes to this Category) Fee: \$901.40 Benefit: 75% = \$676.05 85% = \$816.70	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque mater with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injectio of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of graft and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.)	
38240	(See para TN.8.52 of explanatory notes to this Category) Fee: \$1,081.65 Benefit: 75% = \$811.25 85% = \$996.95	
	USE OF A CORONARY PRESSURE WIRE during selective fractional flow reserve (FFR) and coronary flow reserve (CFR) artery or graft lesions (stenosis of 30-70%), to determine wheth where previous stress testing has either not been performed or) in one or more intermediate coronary her revascularisation should be performed
38241	Fee: \$477.20 Benefit: 75% = \$357.90 85% = \$405.65	
	PLACEMENT OF CATHETER(S) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies (Anaes.)	
38243	(See para TN.8.52 of explanatory notes to this Category) Fee: \$450.70 Benefit: 75% = \$338.05 85% = \$383.10	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.)	
38246	(See para TN.8.52 of explanatory notes to this Category) Fee: \$901.40 Benefit: 75% = \$676.05 85% = \$816.70	
	TEMPORARY TRANSVENOUS PACEMAKING ELECTRO	DDE, insertion of (Anaes.)
38256	Fee: \$271.55 Benefit: 75% = \$203.70 85% = \$230.85	
	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL S catheterisations before and after balloon dilatation (Anaes.) (A	•
38270	Fee: \$926.90 Benefit: 75% = \$695.20 85% = \$842.20	
	ATRIAL SEPTAL DEFECT closure, with septal occluder or other similar device, by transcatheter approach (Anaes.) (Assist.)	
38272	Fee: \$926.90 Benefit: 75% = \$695.20 85% = \$842.20	
	Patent ductus arteriosus, transcatheter closure of, including car associated with the service (Anaes.) (Assist.)	diac catheterisation and any imaging
38273	Fee: \$926.90 Benefit: 75% = \$695.20	
38274	Ventricular septal defect, transcatheter closure of, with imaging	g and cardiac catheterisation (Anaes.)

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACIC
	(Assist.)
	Fee: \$926.90 Benefit: 75% = \$695.20
	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.)
38275	Fee: \$302.95 Benefit: 75% = \$227.25 85% = \$257.55
	Transcatheter occlusion of left atrial appendage, and cardiac catheterisation performed by the same practitioner, for stroke prevention in a patient who has non-valvular atrial fibrillation and a contraindication to life-long oral anticoagulation therapy, and is at increased risk of thromboembolism demonstrated by:
	(a) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non-central nervous system systemic embolism; or
	(b) at least 2 of the following risk factors:
	(i) an age of 65 years or more;
	(ii) hypertension;
	(iii) diabetes mellitus;
	(iv) heart failure or left ventricular ejection fraction of 35% or less (or both);
	(v) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque)
	(Anaes.) (Assist.)
38276	(See para TN.8.132 of explanatory notes to this Category) Fee: \$926.90 Benefit: 75% = \$695.20
	IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where:
	- a diagnosis has not been achieved through all other available cardiac investigations; and
	- a neurogenic cause is not suspected; and
	- it has been determined that the patient does not have structural heart disease associated with a high risk of sudden cardiac death.
	including initial programming and testing, as an admitted patient in an approved hospital (Anaes.)
38285	(See para TN.8.61 of explanatory notes to this Category) Fee: \$196.00 Benefit: 75% = \$147.00 85% = \$166.60
	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital (Anaes.)
38286	Fee: \$176.55 Benefit: 75% = \$132.45 85% = \$150.10
	Implantable loop recorder, insertion of, for diagnosis of atrial fibrillation, if:
20200	(a) the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source; and
38288	

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACIO
	(b) the bases of the diagnosis included the following:
	(i) the medical history of the patient;
	(ii) physical examination;
	(iii) brain and carotid imaging;
	(iv) cardiac imaging;
	(v) surface ECG testing including 24-hour Holter monitoring; and
	(c) atrial fibrillation is suspected; and
	(d) the patient:
	(i) does not have a permanent indication for oral anticoagulants; or
	(ii) does not have a permanent oral anticoagulants contraindication;
	including initial programming and testing
	(Anaes.)
	Fee: \$196.00 Benefit: 75% = \$147.00 85% = \$166.60
	CATHETER BASED ARRHYTHMIA ABLATION
	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.)
38287	Fee: \$2,132.05 Benefit: 75% = \$1599.05 85% = \$2047.35
	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.)
38290	Fee: \$2,714.70 Benefit: 75% = \$2036.05
	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.)
38293	Fee: \$2,913.95 Benefit: 75% = \$2185.50 85% = \$2829.25
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
38300	Fee: \$523.60 Benefit: 75% = \$392.70 85% = \$445.10
	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (Anaes.) (Assist.)
38303	Fee: \$671.35 Benefit: 75% = \$503.55 85% = \$586.65
38306	Transluminal insertion of stent or stents into one occlusional site, including associated balloon dilatation of coronary artery, percutaneous or by open exposure, excluding associated radiological services,

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC
	radiological preparation and after-care (Anaes.) (Assist.)	
	(See para TN.8.62 of explanatory notes to this Category) Fee: \$774.55 Benefit: 75% = \$580.95 85% = \$689.85	
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOR including balloon angioplasty with no stent insertion, where:	OMY of 1 coronary artery,
	- no lesion of the coronary artery has been stented; and	
	- each lesion of the coronary artery is complex and heavily calcified;	and
	- balloon angioplasty with or without stenting is not suitable;	
	excluding associated radiological services or preparation, and excluding	g aftercare (Anaes.) (Assist.)
38309	(See para TN.8.41 of explanatory notes to this Category) Fee: \$899.60 Benefit: 75% = \$674.70 85% = \$814.90	
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOR including balloon angioplasty with insertion of 1 or more stents, where	
	- no lesion of the coronary artery has been stented; and	
	- each lesion of the coronary artery is complex and heavily calcified;	and
	- balloon angioplasty with or without stenting is not suitable;	
	excluding associated radiological services or preparation, and excluding	g aftercare (Anaes.) (Assist.)
38312	(See para TN.8.41 of explanatory notes to this Category) Fee: \$1,150.45 Benefit: 75% = \$862.85 85% = \$1065.75	
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOR artery, including balloon angioplasty with no stent insertion, where:	OMY of more than 1 coronary
	- no lesion of the coronary arteries has been stented; and	
	- each lesion of the coronary arteries is complex and heavily calcified	l; and
	- balloon angioplasty with or without stenting is not suitable;	
	excluding associated radiological services or preparation, and excluding	g aftercare (Anaes.) (Assist.)
38315	(See para TN.8.41 of explanatory notes to this Category) Fee: \$1,235.30 Benefit: 75% = \$926.50 85% = \$1150.60	
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOR artery, including balloon angioplasty, with insertion of 1 or more stents	5
	- no lesion of the coronary arteries has been stented; and	
	- each lesion of the coronary arteries is complex and heavily calcified	l; and
	- balloon angioplasty with or without stenting is not suitable,	
	excluding associated radiological services or preparation, and excluding	g aftercare (Anaes.) (Assist.)
38318	(See para TN.8.41 of explanatory notes to this Category)	

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC
	Fee: \$1,611.75 Benefit: 75% = \$1208.85 8	5% = \$1527.05
	MISCELLANEOUS CARDIAC PROCEDURES	
	SINGLE CHAMBER PERMANENT TRANSV replacement of, including cardiac electrophysiolo (Anaes.)	ENOUS ELECTRODE, insertion, removal or ogical services where used for pacemaker implantation
38350	(See para TN.8.60 of explanatory notes to this Catego Fee: \$648.85 Benefit: 75% = \$486.65	ry)
	PERMANENT CARDIAC PACEMAKER, inset resynchronisation therapy, including cardiac elec implantation (Anaes.)	rtion, removal or replacement of, not for cardiac ctrophysiological services where used for pacemaker
38353	(See para TN.8.60 of explanatory notes to this Catego Fee: \$259.55 Benefit: 75% = \$194.70	ry)
	DUAL CHAMBER PERMANENT TRANSVER replacement of, including cardiac electrophysiolo (Anaes.)	NOUS ELECTRODES, insertion, removal or ogical services where used for pacemaker implantation
38356	(See para TN.8.60 of explanatory notes to this Categor Fee: \$850.75 Benefit: 75% = \$638.10	ry)
	method where the leads have been in situ for gre	pacing or defibrillator lead or leads, by percutaneous ater than six months and require removal with locking ity where cardiac surgery is available, in association
38358	(See para TN.8.64 of explanatory notes to this Catego Fee: $$2,913.95$ Benefit: $75\% = 2185.50	ry)
	PERICARDIUM, paracentesis of (excluding after	ercare) (Anaes.)
38359	Fee: \$135.70 Benefit: 75% = \$101.80 85	% = \$115.35
	INTRA-AORTIC BALLOON PUMP, percutane	ous insertion of (Anaes.)
38362	Fee: \$391.10 Benefit: 75% = \$293.35 85	% - \$332.45
50502		ding a cardiac synchronisation device that is capable of
	(a) has:	
	(i) moderate to severe chronic heart failure despite optimised medical therapy; and	(New York Heart Association (NYHA) class III or IV)
	(ii) sinus rhythm; and	
	(iii) a left ventricular ejection fraction of lea	ss than or equal to 35%; and
	(iv) a QRS duration greater than or equal to	o 120 ms; or
	(b) satisfied the requirements mentioned in par resynchronisation therapy device and transve	agraph (a) immediately before the insertion of a cardiac nous left ventricle electrode (Anaes.)
38365	(See para TN.8.63 of explanatory notes to this Catego Fee: \$259.55 Benefit: 75% = \$194.70	ry)
38368	Permanent transvenous left ventricular electrode	, insertion, removal or replacement of through the

T8. SURGI	CAL OPERATIONS	6. CARDIO-THORACIC
a	coronary sinus, for the purpose of cardiac resynchronisation therapy, includi and any associated venogram of left ventricular veins, other than a service a which item 35200 or 38200 applies, for a patient who:	
((a) has:	
	 (i) moderate to severe chronic heart failure (New York Heart Associati despite optimised medical therapy; and 	on (NYHA) class III or IV)
	(ii) sinus rhythm; and	
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and	1
	(iv) a QRS duration greater than or equal to 120 ms; or	
((b) has:	
	 (i) mild chronic heart failure (New York Heart Association (NYHA) cl medical therapy; and 	lass II) despite optimised
	(ii) sinus rhythm; and	
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and	1
	(iv) a QRS duration greater than or equal to 150 ms; or	
((c) satisfied the requirements mentioned in paragraph (a) or (b) immediate cardiac resynchronisation therapy device and transvenous left ventricle e	
	(See para TN.8.63 of explanatory notes to this Category) Fee: \$1,244.20 Benefit: 75% = \$933.15	
	Permanent cardiac synchronisation device capable of defibrillation, insertion for a patient who:	n, removal or replacement of,
((a) has:	
	 (i) moderate to severe chronic heart failure (New York Heart Associati despite optimised medical therapy; and 	ion ((NYHA) class III or IV)
	(ii) sinus rhythm; and	
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and	1
	(iv) a QRS duration greater than or equal to 120 ms; or	
((b) has:	
	 (i) mild chronic heart failure (New York Heart Association (NYHA) cl medical therapy; and 	lass II) despite optimised
	(ii) sinus rhythm; and	
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and	1
	(iv) a QRS duration greater than or equal to 150 ms (Anaes.)	
38371 ((See para TN.8.65 of explanatory notes to this Category)	

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC
	Fee: \$292.45 Benefit: 75% = \$219.35	
	AUTOMATIC DEFIBRILLATOR, insertion of j defibrillation electrodes for, primary prevention of	patches for, or insertion of transvenous endocardial of sudden cardiac death in:
	- patients with a left ventricular ejection fraction a myocardial infarct when the patient has rece	on of less than or equal to 30% at least one month after vived optimised medical therapy; or
		with mild to moderate symptoms (NYHA II and III) n or equal to 35% when the patient has received
	Not being a service associated with a service to	which item 38213 applies (Anaes.) (Assist.)
38384	Fee: \$1,069.50 Benefit: 75% = \$802.15 85	% = \$984.80
	AUTOMATIC DEFIBRILLATOR GENERATC of sudden cardiac death in:	R, insertion or replacement of for, primary prevention
	- patients with a left ventricular ejection fraction a myocardial infarct when the patient has rece	on of less than or equal to 30% at least one month after ived optimised medical therapy; or
		with mild to moderate symptoms (NYHA II and III) n or equal to 35% when the patient has received
	Not being a service associated with a service to of cardiac resynchronisation therapy (Anaes.) (A	which item 38213 applies, not for defibrillators capable ssist.)
38387	Fee: \$292.45 Benefit: 75% = \$219.35 85	% = \$248.60
	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.)	
38390	Fee: \$1,069.50 Benefit: 75% = \$802.15 85	% = \$984.80
		PR, insertion or replacement of for - not for patients with ardia arrhythmias. Not being a service associated with a ssist.)
38393	Fee: \$292.45 Benefit: 75% = \$219.35 85	% = \$248.60
		CIC SURGERY

T8. SUF	GICAL OPERATIO	NS	6. CARDIO-THORACIC
	EMPYEMA, radica	al operation for, involving resection of rib (Anaes.)) (Assist.)
38415	Fee: \$405.75	Benefit: 75% = \$304.35 85% = \$344.90	
	THORACOTOMY	, exploratory, with or without biopsy (Anaes.) (As	sist.)
38418	Fee: \$973.75	Benefit: 75% = \$730.35	
	THORACOTOMY	, with pulmonary decortication (Anaes.) (Assist.)	
38421	Fee: \$1,556.50	Benefit: 75% = \$1167.40	
	THORACOTOMY (Anaes.) (Assist.)	, with pleurectomy or pleurodesis, OR ENUCLEA	TION OF HYDATID cysts
38424	Fee: \$973.75	Benefit: 75% = \$730.35	
	THORACOPLAST	Y (complete) - 3 or more ribs (Anaes.) (Assist.)	
38427	Fee: \$1,202.35	Benefit: 75% = \$901.80	
	THORACOPLAST	Y (in stages) each stage (Anaes.) (Assist.)	
38430	Fee: \$619.65	Benefit: 75% = \$464.75	
		<i>I</i> , with or without division of pleural adhesions, in	cluding insertion of intercostal
	catheter where nece	essary, with or without biopsy (Anaes.)	
38436	Fee: \$253.75	Benefit: 75% = \$190.35	
		MY or LOBECTOMY or SEGMENTECTOMY n em 38418 applies (Anaes.) (Assist.)	ot being a service associated with a
38438	Fee: \$1,556.50	Benefit: 75% = \$1167.40	
	LUNG, wedge rese	ction of (Anaes.) (Assist.)	
38440	Fee: \$1,165.55	Benefit: 75% = \$874.20	
		CTOMY or PNEUMONECTOMY including resec mal mediastinal node dissection (Anaes.) (Assist.)	tion of chest wall, diaphragm,
38441	Fee: \$1,844.25	Benefit: 75% = \$1383.20	
	THORACOTOMY	or STERNOTOMY, for removal of thymus or me	ediastinal tumour (Anaes.) (Assist.)
38446	Fee: \$1,202.35	Benefit: 75% = \$901.80	
	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.)		without cardiopulmonary bypass
38447	Fee: \$1,556.50	Benefit: 75% = \$1167.40	
	MEDIASTINUM,	cervical exploration of, with or without biopsy (An	naes.) (Assist.)
38448	Fee: \$368.85	Benefit: 75% = \$276.65	
	PERICARDIECTO (Anaes.) (Assist.)	MY via sternotomy or anterolateral thoracotomy	with cardiopulmonary bypass
38449	Fee: \$2,177.50	Benefit: 75% = \$1633.15	
38450		ransthoracic open surgical drainage of (Anaes.) (A	.ssist.)

T8. SUF		ONS 6. CARDIO-THORACIO	
	Fee: \$870.35	Benefit: 75% = \$652.80	
	PERICARDIUM	subxiphoid open surgical drainage of (Anaes.) (Assist.)	
38452	Fee: \$582.90	Benefit: 75% = \$437.20	
	TRACHEAL exc	sion and repair without cardiopulmonary bypass (Anaes.) (Assist.)	
20152	Ecc. \$1 749 45	Dama (14, 750/ 01211.25	
38453	Fee: \$1,748.45	Benefit: 75% = \$1311.35 CISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.)	
38455	Fee: \$2,364.95	Benefit: 75% = \$1773.75	
		IC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or on more than 1 of those organs, not being a service to which another item in this Group Assist.)	
38456	Fee: \$1,556.50	Benefit: 75% = \$1167.40	
	PECTUS EXCA	ATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.)	
38457	Fee: \$1,453.15	Benefit: 75% = \$1089.90	
50+57		ATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.)	
38458	Fee: \$774.55	Benefit: 75% = \$580.95	
	STERNAL WIRE OR WIRES, removal of (Anaes.)		
38460	Fee: \$279.80	Benefit: 75% = \$209.85	
	STERNOTOMY	WOUND, debridement of, not involving reopening of the mediastinum (Anaes.)	
38462	Fee: \$331.65	Benefit: 75% = \$248.75	
		WOUND, debridement of, involving curettage of infected bone with or without but not involving reopening of the mediastinum (Anaes.)	
38464	Fee: \$360.50	Benefit: 75% = \$270.40	
	STERNUM, reop without rewiring	eration on, for dehiscence or infection involving reopening of the mediastinum, with or (Anaes.) (Assist.)	
38466	Fee: \$973.35	Benefit: 75% = \$730.05	
		MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps m (Anaes.) (Assist.)	
38468	Fee: \$1,499.75	Benefit: 75% = \$1124.85	
	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flap and greater omentum (Anaes.) (Assist.)		
38469	Fee: \$1,748.45	Benefit: 75% = \$1311.35	
		CARDIAC SURGERY PROCEDURES	
	PERMANENT N (Assist.)	YOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.)	
38470	(See para TN.8.67 Fee: \$973.75	of explanatory notes to this Category) Benefit: 75% = \$730.35	

T8. SURGICAL OPERATIONS 6. CARDIO-TH		6. CARDIO-THORACIC
	PERMANENT PACEMAKER ELECTRODE, insertion by open su	urgical approach (Anaes.) (Assist.)
38473	(See para TN.8.67 of explanatory notes to this Category) Fee: \$582.90 Benefit: 75% = \$437.20	
	VALVULAR PROCEDURES	
	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.) (Assist.)	
38475	(See para TN.8.67 of explanatory notes to this Category) Fee: \$845.05 Benefit: 75% = \$633.80	
	VALVE ANNULOPLASTY with insertion of ring not being a serv (Anaes.) (Assist.)	ice to which item 38478 applies
38477	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,035.40 Benefit: 75% = \$1526.55	
	VALVE ANNULOPLASTY with insertion of ring performed in co (Anaes.) (Assist.)	njunction with item 38480 or 38481
38478	(See para TN.8.67 of explanatory notes to this Category) Fee: \$985.95 Benefit: 75% = \$739.50	
	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.)	
38480	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,035.40 Benefit: 75% = \$1526.55	
	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.)	
38481	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,317.15 Benefit: 75% = \$1737.90	
	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, r 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (As	•
38483	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,748.45 Benefit: 75% = \$1311.35	
	MITRAL ANNULUS, reconstruction of, after decalcification, when surgery (Anaes.) (Assist.)	n performed in association with valve
38485	(See para TN.8.67 of explanatory notes to this Category) Fee: \$830.15 Benefit: 75% = \$622.65	
	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.)	
38487	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,748.45 Benefit: 75% = \$1311.35	
	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.)	
38488	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,940.15 Benefit: 75% = \$1455.15	
	VALVE REPLACEMENT with allograft (subcoronary or cylindric (Anaes.) (Assist.)	al implant), or unstented xenograft
38489	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,307.40 Benefit: 75% = \$1730.55	

T8. SURGICAL OPERATIONS		6. CARDIO-THORACIC
	SUB-VALVULAR STRUCTURES, reconstruction and re-in tricuspid valve replacement (Anaes.) (Assist.)	nplantation of, associated with mitral and
38490	(See para TN.8.67 of explanatory notes to this Category) Fee: \$563.40 Benefit: 75% = \$422.55	
	OPERATIVE MANAGEMENT of acute infective endocard (Anaes.) (Assist.)	itis, in association with heart valve surgery
38493	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,988.90 Benefit: 75% = \$1491.70	
	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.)
38495	(See para AN.33.1, TN.8.135 of explanatory notes to this Category Fee: \$1,455.10 Benefit: 75% = \$1091.35 85% = \$1370.	
	SURGERY FOR ISCHAEMIC H	EART DISEASE
	ARTERY HARVESTING (other than internal mammary), for	or coronary artery bypass (Anaes.) (Assist.)
38496	(See para TN.8.67 of explanatory notes to this Category) Fee: \$633.95 Benefit: 75% = \$475.50	
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using saphenous vein graft or graft only, including harvesting of vein graft material where performed, not being a service asociated with service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.)	
38497	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,080.35 Benefit: 75% = \$1560.30	
	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmona bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.)	
38498	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,080.35 Benefit: 75% = \$1560.30	
	CORONARY ARTERY BYPASS with cardiopulmonary by without vein graft or grafts, including harvesting of internal where performed, not being a service associated with a servi 38503 or 38504 apply (Anaes.) (Assist.)	mammary artery or vein graft material
38500	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,235.20 Benefit: 75% = \$1676.40	
	CORONARY ARTERY BYPASS with the aid of tissue stab bypass, using single arterial graft, with or without vein graft mammary artery or vein graft material where performed, eith minimally invasive technique and where a stand-by perfusio with a service to which items 38497, 38498, 38500, 38503,	or grafts, including harvesting of internal her via a median sternotomy or other nist is present, not being a service associated
38501	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,235.20 Benefit: 75% = \$1676.40	

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, us without vein graft or grafts, including harvesting of internal mamma where performed, not being a service associated with a service to wh 38501 or 38504 apply (Anaes.) (Assist.)	ry artery or vein graft material
38503	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,426.90 Benefit: 75% = \$1820.20	
	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, bypass, using 2 or more arterial grafts, with or without vein graft or internal mammary artery or vein graft material where performed, eit minimally invasive technique and where a stand-by perfusionist is p with a service to which items 38497, 38498, 38500, 38501, 38503 o	grafts, including harvesting of her via a median sternotomy or other resent, not being a service associated
38504	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,426.90 Benefit: 75% = \$1820.20	
	CORONARY ENDARTERECTOMY, by open operation, including each vessel (Anaes.) (Assist.)	g repair with 1 or more patch grafts,
38505	(See para TN.8.67 of explanatory notes to this Category) Fee: \$281.70 Benefit: 75% = \$211.30	
	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist	t.)
38506	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,652.25 Benefit: 75% = \$1239.20	
	LEFT VENTRICULAR ANEURYSM resection with primary repair	r (Anaes.) (Assist.)
38507	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,939.75 Benefit: 75% = \$1454.85	
	LEFT VENTRICULAR ANEURYSM resection with patch reconstr (Assist.)	ruction of the left ventricle (Anaes.)
38508	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,426.90 Benefit: 75% = \$1820.20	
	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.)	
38509	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,426.90 Benefit: 75% = \$1820.20	
	ARRHYTHMIA SURGERY	
	DIVISION OF ACCESSORY PATHWAY, isolation procedure, properinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.)	ocedure on atrioventricular node or
38512	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,132.05 Benefit: 75% = \$1599.05	
	DIVISION OF ACCESSORY PATHWAY, isolation procedure, properinodal tissues involving both atrial chambers and including curat (Anaes.) (Assist.)	
38515	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,714.70 Benefit: 75% = \$2036.05	
	VENTRICULAR ARRHYTHMIA with mapping and muscle ablati (Anaes.) (Assist.)	on, with or without aneurysmeotomy
38518		

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORAC
	(See para TN.8.67 of explanatory notes to this Category)
	Fee: \$2,913.95 Benefit: 75% = \$2185.50
	PROCEDURES ON THORACIC AORTA
	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or replacement or coronary artery implantation (Anaes.) (Assist.)
38550	(See para TN.8.67 of explanatory notes to this Category) Fee: $$2,180.50$ Benefit: $75\% = 1635.40
	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair without implantation of coronary arteries (Anaes.) (Assist.)
38553	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,763.25 Benefit: 75% = \$2072.45
	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair and implantation of coronary arteries (Anaes.) (Assist.)
38556	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,154.40 Benefit: 75% = \$2365.80
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving value replacement or repair or coronary artery implantation (Anaes.) (Assist.)
38559	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,571.50 Benefit: 75% = \$1928.65
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.)
38562	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,154.40 Benefit: 75% = \$2365.80
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)
38565	(See para TN.8.67 of explanatory notes to this Category)Fee: $$3,537.95$ Benefit: $75\% = 2653.50
	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means (Anaes.) (Assist.)
38568	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,892.75 Benefit: 75% = \$1419.60
	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypa (Anaes.) (Assist.)
38571	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,084.60 Benefit: 75% = \$1563.45
_	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.)
38572	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,018.85 Benefit: 75% = \$1514.15
	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.)
38577	(See para TN.8.67 of explanatory notes to this Category)

T8. SUF	RGICAL OPERAT	IONS	6. CARDIO-THORACIC	
	Fee: \$563.40	Benefit: 75% = \$422.55		
		TECHNIQUES FOR PRE	SERVATION OF ARRESTED HEART	
		N of the coronary sinus for, ar ardioplegia, including pressure	d supervision of, the retrograde administration of blood or monitoring (Assist.)	
38588	(See para TN.8.67 Fee: \$422.70	of explanatory notes to this Cate Benefit: 75% = \$317.05	gory)	
		CIRCULATORY	SUPPORT PROCEDURES	
			onary bypass excluding post-operative management, not ich another item in this Subgroup applies (Anaes.)	
38600	(See para TN.8.67 Fee: \$1,556.50	of explanatory notes to this Cate Benefit: 75% = \$1167.40	gory)	
	PERIPHERAL ((Anaes.) (Assist	-	Imonary bypass excluding post-operative management	
38603	(See para TN.8.67 Fee: \$973.75	of explanatory notes to this Cate Benefit: 75% = \$730.35	gory)	
	INTRA-AORTI	C BALLOON PUMP, insertio	n of, by arteriotomy (Anaes.) (Assist.)	
38609	(See para TN.8.67 Fee: \$486.80	of explanatory notes to this Cate Benefit: 75% = \$365.10	gory)	
	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.)			
38612	(See para TN.8.67 Fee: \$545.70	of explanatory notes to this Cate Benefit: 75% = \$409.30		
	INTRA-AORTI (Assist.)	C BALLOON PUMP, remova	l of, with closure of artery by patch graft (Anaes.)	
38613	(See para TN.8.67 Fee: \$684.85	of explanatory notes to this Cate Benefit: 75% = \$513.65	gory)	
	Insertion of a lef	ft or right ventricular assist dev	rice, for use as:	
	(a) a bridge to	cardiac transplantation in patie	ents with refractory heart failure who are:	
	(i) currently	on a heart transplant waiting	ist, or	
	(ii) expected the ventricular	d to be suitable candidates for	cardiac transplantation following a period of support on	
	assist devic	e; 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;			
38615	-		ventricular assist device as destination therapy in the are not expected to be suitable candidates for cardiac	

T8. SUR	RGICAL OPERATIONS	6. CARDIO-THORACIC
	transplantation (Anaes.) (Assist.)	
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,556.50 Benefit: 75% = \$1167.40	
	Insertion of a left and right ventricular assist device, for use as:	
	(a) a bridge to cardiac transplantation in patients with refractory hea	rt failure who are:
	(i) currently on a heart transplant waiting list, or	
	(ii) expected to be suitable candidates for cardiac transplantation the ventricular	following a period of support on
	assist device; or	
	(b) acute post cardiotomy support for failure to wean from cardioput	lmonary transplantation; or
	(c) cardio-respiratory support for acute cardiac failure which is likel support of less than 6	y to recover with short term
	weeks;	
	not being a service associated with the use of a ventricular assist device management of patients with heart failure who are not expected to be transplantation (Anaes.) (Assist.)	10
38618	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,940.15 Benefit: 75% = \$1455.15	
	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, a (Anaes.) (Assist.)	s an independent procedure
38621	(See para TN.8.67 of explanatory notes to this Category) Fee: \$774.55 Benefit: 75% = \$580.95	
	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of (Anaes.) (Assist.)	, as an independent procedure
38624	(See para TN.8.67 of explanatory notes to this Category) Fee: \$870.35 Benefit: 75% = \$652.80	
	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS (DEVICE CANNULAE, adjustment and re-positioning of, by open op these devices (Anaes.) (Assist.)	
38627	(See para TN.8.67 of explanatory notes to this Category) Fee: \$680.30 Benefit: 75% = \$510.25	
	RE-OPERATION	
	PATENT DISEASED coronary artery bypass vein graft or grafts, diss oversewing of (Anaes.) (Assist.)	section, disconnection and
38637	(See para TN.8.67 of explanatory notes to this Category) Fee: \$563.40 Benefit: 75% = \$422.55	
	RE-OPERATION via median sternotomy, for any procedure, includin where the time taken to divide the adhesions is 45 minutes or less (An	• •
38640	(See para TN.8.69, TN.8.67 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERA	TIONS	6. CARDIO-THORACIC
	Fee: \$973.75	Benefit: 75% = \$730.35	
		MISCELLANEOUS CARDI	OTHORACIC SURGICAL PROCEDURES
		MY OR STERNOTOMY inv xceeds 45 minutes (Anaes.) (A	olving division of adhesions where the time taken to divide Assist.)
38643	(See para TN.8.6 Fee: \$1,084.50	7 of explanatory notes to this Cat Benefit: 75% = \$813.40	egory)
		MY OR STERNOTOMY inv hesions exceeds 2 hours (Ana	olving division of extensive adhesions where the time taken es.) (Assist.)
38647	(See para TN.8.6 Fee: \$2,168.65	7 of explanatory notes to this Cat Benefit: 75% = \$1626.50	
	MYOMECTON	MY or MYOTOMY for hyper	rophic obstructive cardiomyopathy (Anaes.) (Assist.)
38650	(See para TN.8.6 Fee: \$1,940.15	7 of explanatory notes to this Cat Benefit: 75% = \$1455.15	
	OPEN HEART (Assist.)	SURGERY, not being a servi	ce to which another item in this Group applies (Anaes.)
38653	(See para TN.8.6 Fee: \$1,940.15	7 of explanatory notes to this Cat Benefit: 75% = \$1455.15	
		ventricular electrode, insertion liac resynchronisation therapy	h, removal or replacement of via open thoracotomy, for the for a patient who:
	(a) has:		
		ate to severe chronic heart fail optimised medical therapy; an	ure (New York Heart Association (NYHA) class III or IV)
	(ii) sinus r	rhythm; and	
	(iii) a left	ventricular ejection fraction o	f less than or equal to 35%; and
	(iv) a QRS	S duration greater than or equa	al to 120 ms; or
	(b) has:		
		nronic heart failure (New York therapy; and	Heart Association (NYHA) class II) despite optimised
	(ii) sinus r	rhythm; and	
	(iii) a left	ventricular ejection fraction o	f less than or equal to 35%; and
	(iv) a QRS	S duration greater than or equa	l to 150 ms; or
			paragraph (a) or (b) immediately before the insertion of a and transvenous left ventricle electrode
	(Anaes.) (Assis	t.)	
38654	(See para TN.8.6 Fee: \$1,244.20	3, TN.8.67 of explanatory notes t Benefit: 75% = \$933.15	o this Category)

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC
	THORACOTOMY or median sternotomy for post-operative bleed	ling (Anaes.) (Assist.)
38656	(See para TN.8.67 of explanatory notes to this Category) Fee: \$973.75 Benefit: 75% = \$730.35	
	CARDIAC TUMOURS	
	CARDIAC TUMOUR, excision of, involving the wall of the atriu or conduit reconstruction (Anaes.) (Assist.)	m or inter-atrial septum, without patch
38670	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,939.75 Benefit: 75% = \$1454.85	
	CARDIAC TUMOUR, excision of, involving the wall of the atriu reconstruction with patch or conduit (Anaes.) (Assist.)	m or inter-atrial septum, requiring
38673	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,183.25 Benefit: 75% = \$1637.45	
56675	CARDIAC TUMOUR arising from ventricular myocardium, parti (Assist.)	al thickness excision of (Anaes.)
38677	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,042.50 Benefit: 75% = \$1531.90	
	CARDIAC TUMOUR arising from ventricular myocardium, full t or reconstruction (Anaes.) (Assist.)	hickness excision of including repair
38680	(See para TN.8.70 of explanatory notes to this Category) Fee: \$2,422.70 Benefit: 75% = \$1817.05 85% = \$2338.00	
	CONGENITAL CARDIAC SURGERY	
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other sing without cardiopulmonary bypass, for congenital heart disease (An	
38700	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,084.50 Benefit: 75% = \$813.40	
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other sing with cardiopulmonary bypass, for congenital heart disease (Anaes	
38703	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,954.90 Benefit: 75% = \$1466.20	
	AORTA, anastomosis or repair of, without cardiopulmonary bypa (Anaes.) (Assist.)	ss, for congenital heart disease
38706	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,851.55 Benefit: 75% = \$1388.70	
	AORTA, anastomosis or repair of, with cardiopulmonary bypass, (Assist.)	for congenital heart disease (Anaes.)
38709	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,168.65 Benefit: 75% = \$1626.50	
	AORTIC INTERRUPTION, repair of, for congenital heart disease	e (Anaes.) (Assist.)
38712	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,604.15 Benefit: 75% = \$1953.15	
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of	f, without cardiopulmonary bypass, for

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORA	1CIC
	congenital heart disease (Anaes.) (Assist.)	
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,733.60 Benefit: 75% = \$1300.20	
	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	or
38718	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,168.65 Benefit: 75% = \$1626.50	
	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disea (Anaes.) (Assist.)	ise
38721	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,519.75 Benefit: 75% = \$1139.85	
	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	
38724	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,168.65 Benefit: 75% = \$1626.50	
	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not bein service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, f congenital heart disease (Anaes.) (Assist.)	
38727	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,519.75 Benefit: 75% = \$1139.85	
	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, f congenital heart disease (Anaes.) (Assist.)	
38730	Fee: \$2,168.65 Benefit: 75% = \$1626.50	
	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmon bypass, for congenital heart disease (Anaes.) (Assist.)	ary
38733	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,519.75 Benefit: 75% = \$1139.85	
	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	r
38736	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,168.65 Benefit: 75% = \$1626.50	
	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	
38739	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,954.90 Benefit: 75% = \$1466.20	
	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.)	
38742	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,954.90 Benefit: 75% = \$1466.20	
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.)	

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC	
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,168.65 Benefit: 75% = \$1626.50		
	VENTRICULAR SEPTECTOMY, for congenital heart disease (Ana	ues.) (Assist.)	
38748	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,168.65 Benefit: 75% = \$1626.50		
	Ventricular septal defect, closure by direct suture or patch (Anaes.) (Assist.)	
38751	(See para TN.8.67 of explanatory notes to this Category)Fee: $$2,168.65$ Benefit: $75\% = 1626.50		
	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for (Assist.)	congenital heart disease (Anaes.)	
20754	(See para TN.8.67 of explanatory notes to this Category)		
38754	Fee: \$2,714.70 Benefit: 75% = \$2036.05	ana (Amana) (Anist)	
	EXTRACARDIAC CONDUIT, insertion of, for congenital heart dis	ease (Anaes.) (Assist.)	
38757	(See para TN.8.67 of explanatory notes to this Category) Fee: $$2,168.65$ Benefit: $75\% = 1626.50		
38737	EXTRACARDIAC CONDUIT, replacement of, for congenital heart	disease (Anaes.) (Assist.)	
38760	(See para TN.8.67 of explanatory notes to this Category) Fee: $$2,168.65$ Benefit: $75\% = 1626.50		
	VENTRICULAR MYECTOMY, for relief of ventricular obstruction disease (Anaes.) (Assist.)	, right or left, for congenital heart	
38763	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,168.65 Benefit: 75% = \$1626.50		
	VENTRICULAR AUGMENTATION, right or left, for congenital here	eart disease (Anaes.) (Assist.)	
38766	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,168.65 Benefit: 75% = \$1626.50		
	MISCELLANEOUS PROCEDURES ON TH	IE CHEST	
	THORACIC CAVITY, aspiration of, for diagnostic purposes, not be service to which item 38803 applies	ing a service associated with a	
38800	Fee: \$39.10 Benefit: 75% = \$29.35 85% = \$33.25		
	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample		
38803	Fee: \$78.15 Benefit: 75% = \$58.65 85% = \$66.45		
	INTERCOSTAL DRAIN, insertion of, not involving resection of rib	(excluding aftercare) (Anaes.)	
38806	Fee: \$135.70 Benefit: 75% = \$101.80 85% = \$115.35		
	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not invo aftercare) (Anaes.)	olving resection of rib (excluding	
38809	Fee: \$167.20 Benefit: 75% = \$125.40 85% = \$142.15		
	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.)		
20012			
38812	Fee: \$212.50 Benefit: 75% = \$159.40 85% = \$180.65		

T8. SUF	RGICAL OPERAT	TIONS 7. NEUROSURGICAL		
	Group T8. Surg	ical Operations		
		Subgroup 7. Neurosurgical		
		GENERAL		
	LUMBAR PUN	CTURE (Anaes.)		
39000	Fee: \$76.50	Benefit: 75% = \$57.40 85% = \$65.05		
	CISTERNAL P	UNCTURE (Anaes.)		
39003	Fee: \$87.00	Benefit: 75% = \$65.25 85% = \$73.95		
	VENTRICULA	R PUNCTURE (not including burr-hole) (Anaes.)		
39006	Fee: \$161.95	Benefit: 75% = \$121.50 85% = \$137.70		
	SUBDURAL H	AEMORRHAGE, tap for, each tap (Anaes.)		
39009	Fee: \$60.30	Benefit: 75% = \$45.25		
		single, preparatory to ventricular puncture or for inspection purpose - not being a service r item applies (Anaes.)		
39012	Fee: \$241.40	Benefit: 75% = \$181.05		
39013	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthet or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes.) (See para TN.8.4 of explanatory notes to this Category)			
39013	Fee: \$110.90 Benefit: 75% = \$83.20 85% = \$94.30 VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.) (Assist.)			
39015	(See para 1N.8.4) Fee: \$382.00	of explanatory notes to this Category) Benefit: 75% = \$286.50		
	CEREBROSPIN	NAL FLUID reservoir, insertion of (Anaes.) (Assist.)		
39018	Fee: \$382.00	Benefit: 75% = \$286.50		
	PAIN RELIEF			
	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.)			
39100	(See para TN.8.4 Fee: \$241.40	of explanatory notes to this Category) Benefit: $75\% = 181.05 $85\% = 205.20		
	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.)			
39106	Fee: \$1,207.20	Benefit: 75% = \$905.40		
	TRIGEMINAL	GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.)		
39109	Fee: \$450.80	Benefit: 75% = \$338.10 85% = \$383.20		
39112	CRANIAL NEF	RVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.)		

T8. SUF		ONS	7. NEUROSURGICAL	
	Fee: \$1,566.15	Benefit: 75% = \$1174.65		
		US NEUROTOMY of posterior divisions (or rar ociated spinal, epidural or regional nerve block		
39115	(See para TN.8.4 of Fee: \$76.50	explanatory notes to this Category) Benefit: 75% = \$57.40 85% = \$65.05		
		US NEUROTOMY for facet joint denervation by imaging control (Anaes.) (Assist.)	y radio-frequency probe or cryoprobe	
39118	(See para TN.8.4 of Fee: \$302.60	explanatory notes to this Category) Benefit: 75% = \$226.95 85% = \$257.25		
	PERCUTANEOU	JS CORDOTOMY (Anaes.) (Assist.)		
39121	(See para TN.8.4 of Fee: \$641.85	explanatory notes to this Category) Benefit: 75% = \$481.40 85% = \$557.15		
		DR MYELOTOMY, partial or total laminectom n (Anaes.) (Assist.)	y for, or operation for dorsal root entry	
39124	Fee: \$1,642.65	Benefit: 75% = \$1232.00		
		lural SPINAL CATHETER insertion or replace lanted infusion pump, for the management of c		
39125	Fee: \$302.80	Benefit: 75% = \$227.10		
	intrathecal or epic	P, subcutaneous implantation or replacement of lural catheter, and filling of reservoir with a the ning the pump, for the management of chronic i	rapeutic agent or agents, with or	
39126	Fee: \$367.70	Benefit: 75% = \$275.80		
	SUBCUTANEOU chronic intractable	JS RESERVOIR AND SPINAL CATHETER, 2 e pain (Anaes.)	insertion of, for the management of	
39127	(See para TN.8.4 of Fee: \$481.25	explanatory notes to this Category) Benefit: 75% = \$360.95		
	insertion of, and c	P, subcutaneous implantation of, AND intrather connection of pump to catheter, and filling of re thout programming the pump, for the managem	servoir with a therapeutic agent or	
39128	Fee: \$670.50	Benefit: 75% = \$502.90		
	EPIDURAL LEAD, percutaneous placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.)			
39130	(See para TN.8.4 of Fee: \$684.95	explanatory notes to this Category) Benefit: 75% = \$513.75		
	of neurostimulato	epidural or peripheral nerve, management of pat r by a medical practitioner, for the management ctory angina pectoris - each day		
39131	Fee: \$129.85	Benefit: 75% = \$97.40 85% = \$110.40		

T8. SUF	RGICAL OPERAT	IONS	7. NEUROSURGICAL
			PUMP OR removal or repositioning of nanagement of chronic intractable pain (Anaes.)
39133	(See para TN.8.4 c Fee: \$161.95	of explanatory notes to this Category) Benefit: 75% = \$121.50	
	connection of ex		placement of, including placement and nerve electrodes, for the management of chronic gina pectoris (Anaes.) (Assist.)
39134	Fee: \$346.05	Benefit: 75% = \$259.55	
		or pain from refractory angina pectori	rted for the management of chronic intractable is, removal of, performed in the operating theatre
39135	Fee: \$161.95	Benefit: 75% = \$121.50	
		or pain from refractory angina pectori	or the management of chronic intractable is, removal of, performed in the operating theatre
39136	(See para TN.8.4 c Fee: \$161.95	of explanatory notes to this Category) Benefit: 75% = \$121.50	
	neuropathic pain or unsatisfactory	or pain from refractory angina pectori	or the management of chronic intractable is, surgical repositioning to correct displacement test stimulation, not being a service to which item
39137	Fee: \$615.05	Benefit: 75% = \$461.30	
	management of c		including intraoperative test stimulation, for the pain from refractory angina pectoris, to a
39138	Fee: \$684.95	Benefit: 75% = \$513.75	
	Epidural lead, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain fron refractory angina pectoris—to a maximum of 4 leads (H) (Anaes.) (Assist.)		chronic intractable neuropathic pain or pain from
39139	Fee: \$919.60	Benefit: 75% = \$689.70	
	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.)		control, with epidurogram and epidural
39140	Fee: \$297.55	Benefit: 75% = \$223.20 85% = \$2	252.95
		PERIPHERAL	NERVES
CUTANEOUS NERVE (including digital nerve), primary repair of, using mic (Anaes.) (Assist.)		ary repair of, using microsurgical techniques	
39300	Fee: \$359.00	Benefit: 75% = \$269.25	
39300		NERVE (including digital nerve), second	ndary repair of, using microsurgical techniques

T8. SUF	GICAL OPERA	IONS	7. NEUROSURGICAL	
	NERVE TRUN	K, primary repair of, using microsurg	ical techniques (Anaes.) (Assist.)	
39306	Fee: \$687.65	Benefit: 75% = \$515.75		
	NERVE TRUN	K, secondary repair of, using microsu	rgical techniques (Anaes.) (Assist.)	
39309	Fee: \$725.80	Benefit: 75% = \$544.35		
	NERVE TRUN	K, (interfascicular), neurolysis of, usi	ng microsurgical techniques (Anaes.) (Assist.)	
39312	Fee: \$404.95	Benefit: 75% = \$303.75		
	NERVE TRUN techniques (Ana		ng harvesting of nerve graft using microsurgical	
39315	Fee: \$1,046.70	Benefit: 75% = \$785.05		
	CUTANEOUS (Anaes.) (Assis		ve graft to, using microsurgical techniques	
39318	Fee: \$649.45	Benefit: 75% = \$487.10		
	NERVE, transp	osition of (Anaes.) (Assist.)		
39321	Fee: \$481.25	Benefit: 75% = \$360.95		
		US NEUROTOMY by cryotherapy of another item applies (Anaes.) (Assis	or radiofrequency lesion generator, not being a t.)	
39323	Fee: \$281.25	Benefit: 75% = \$210.95 85% = \$	\$239.10	
NEURECTOMY, NI operation (Anaes.) (A			our from superficial peripheral nerve, by open	
39324	(See para TN.8.4 Fee: \$281.25	of explanatory notes to this Category) Benefit: 75% = \$210.95 85% = \$	\$239.10	
			our from deep peripheral or cranial nerve, by open 1576, 41578 or 41579 applies (Anaes.) (Assist.)	
39327	(See para TN.8.4 Fee: \$481.35	of explanatory notes to this Category) Benefit: 75% = \$361.05		
		by open operation without transpositi 12 applies (Anaes.) (Assist.)	on, not being a service associated with a service to	
39330	Fee: \$281.25	Benefit: 75% = \$210.95		
	CARPAL TUN	NEL RELEASE (division of transvers	se carpal ligament), by any method (Anaes.)	
39331	Fee: \$281.25	Benefit: 75% = \$210.95 85% = \$	\$239.10	
	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this (Anaes.) (Assist.)		rvice to which another item in this Group applies	
39333	Fee: \$404.95	Benefit: 75% = \$303.75 85% = \$	\$344.25	
	CRANIAL NERVES			
	VESTIBULAR NERVE, section of, via posterior fossa (Anaes.) (Assist.)			
39500	Fee: \$1,291.25	Benefit: 75% = \$968.45		
39503	FACIO-HYPO	GLOSSAL nerve or FACIO-ACCESS	ORY nerve, anastomosis of (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERAT	IONS	7. NEUROSURGICAL
	Fee: \$970.30	Benefit: 75% = \$727.75	
		CRANIC	-CEREBRAL INJURIES
	INTRACRANIA (Assist.)	AL HAEMORRHAGE, burr	hole craniotomy for - including burr-holes (Anaes.)
39600	Fee: \$481.25	Benefit: 75% = \$360.95	
	INTRACRANIA of haematoma (A		plastic craniotomy or extensive craniectomy and removal
39603	Fee: \$1,214.85	Benefit: 75% = \$911.15	
	FRACTURED S	KULL, depressed or commi	nuted, operation for (Anaes.) (Assist.)
39606	Fee: \$809.85	Benefit: 75% = \$607.40	
	FRACTURED S	KULL, compound, without	dural penetration, operation for (Anaes.) (Assist.)
39609	Fee: \$970.30	Benefit: 75% = \$727.75	
		KULL, compound, depresse tion for (Anaes.) (Assist.)	ed or complicated, with dural penetration and brain
39612	Fee: \$1,138.40	Benefit: 75% = \$853.80	
	FRACTURED S (Anaes.) (Assist.		otorrhoea, repair of by cranioplasty or endoscopic approach
39615	Fee: \$1,214.85	Benefit: 75% = \$911.15	
		SKU	LL BASE SURGERY
		DLVING ANTERIOR CRA kull base, and dural repair (A	NIAL FOSSA, removal of, involving craniotomy, radical Anaes.) (Assist.)
39640	(See para TN.8.70 Fee: \$3,080.15	of explanatory notes to this Ca Benefit: 75% = \$2310.1	
			NIAL FOSSA, removal of, involving frontal craniotomy asal sinus extension (intracranial procedure) (Anaes.)
39642	(See para TN.8.70 Fee: \$3,238.25	of explanatory notes to this Ca Benefit: 75% = \$2428.70	
	with lateral rhind	otomy and radical clearance	NIAL FOSSA, removal of, involving frontal craniotomy of paranasal sinus and orbital fossa extensions, with e, (intracranial procedure) (Anaes.) (Assist.)
39646	(See para TN.8.70 Fee: \$3,712.05	of explanatory notes to this Ca Benefit: 75% = \$2784.03	
	of, craniotomy a		AL FOSSA AND INFRA-TEMPORAL FOSSA, removal al excision, with division and reconstruction of zygomatic st.)
39650	(See para TN.8.70 Fee: \$2,685.25	of explanatory notes to this Ca Benefit: 75% = \$2013.9	
39653			, removal of, by supra and infratentorial approaches for nial procedure), not being a service to which item 39654 or

GICAL OPERATIONS	7. NEUROSURGICAL
39656 applies (Anaes.) (Assist.)	
(See para TN.8.70 of explanatory notes to this Category) Fee: \$4,778.40 Benefit: 75% = \$3583.80	
(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,475.25 Benefit: 75% = \$2606.45	
(See para TN.8.70 of explanatory notes to this Category) Fee: \$2,606.35 Benefit: 75% = \$1954.80	
TUMOUR INVOLVING THE CLIVUS, radical or sub-total rad transmaxillary approach (Anaes.) (Assist.)	lical excision of, involving transoral or
(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,080.15 Benefit: 75% = \$2310.15	
(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,080.15 Benefit: 75% = \$2310.15	
(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,080.15 Benefit: 75% = \$2310.15	
INTRA-CRANIAL NEOPLAS	SMS
SKULL TUMOUR, benign or malignant, excision of, excluding	cranioplasty (Anaes.) (Assist.)
Fee: \$565.50 Benefit: 75% = \$424.15	
INTRACRANIAL tumour, cyst or other brain tissue, burr-hole a (Anaes.) (Assist.)	and biopsy of, or drainage of, or both
Fee: \$527.30 Benefit: 75% = \$395.50	
INTRACRANIAL tumour, biopsy or decompression of via osteo decompression of via osteoplastic flap (Anaes.) (Assist.)	oplastic flap OR biopsy and
Fee: \$1,130.65 Benefit: 75% = \$848.00	
Fee: \$1,612.15 Benefit: 75% = \$1209.15	
Fee: \$2,910.85 Benefit: 75% = \$2183.15	
	39656 applies (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) Fee: \$4,778.40 Benefit: 75% = \$3583.80 PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supradical or sub-total radical excision, (intracranial procedure), con (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) Fee: \$3,475.25 Benefit: 75% = \$2606.45 PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supradical or sub-total radical excision, (intracranial procedure), con (See para TN.8.70 of explanatory notes to this Category) Fee: \$2,606.35 Benefit: 75% = \$1954.80 TUMOUR INVOLVING THE CLIVUS, radical or sub-total raditransmaxillary approach (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) Fee: \$3,080.15 Benefit: 75% = \$2310.15 TUMOUR OR VASCULAR LESION OF CAVERNOUS SINU craniotomy with or without intracranial carotid artery exposure (See para TN.8.70 of explanatory notes to this Category) Fee: \$3,080.15 Benefit: 75% = \$2310.15 TUMOUR OR VASCULAR LESION OF FORAMEN MAGNU transcondylar or far lateral suboccipital approach (Anaes.) (Assist) (See para TN.8.70 of explanatory notes to this Category) Fee: \$3,080.15 Benefit: 75% = \$2310.15 TUMOUR OR VASCULAR LESION OF FORAMEN MAGNU transcondylar or far lateral suboccipital approach (Anaes.) (Assist) SKULL TUMOUR, benign or malignant, excision of, excl

T8. SUF	RGICAL OPERAT	ONS 7. NEUROSURGICAI			
	PITUITARY TU	MOUR, removal of, by transcranial or transphenoidal approach (Anaes.) (Assist.)			
39715	Fee: \$2,017.05	Benefit: 75% = \$1512.80			
	ARACHNOIDAL CYST, craniotomy for (Anaes.) (Assist.)				
39718	Fee: \$886.25	Benefit: 75% = \$664.70			
	CRANIOTOMY etc (Anaes.) (Ass	, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling ist.)			
39721	Fee: \$809.85	Benefit: 75% = \$607.40			
		CEREBROVASCULAR DISEASE			
	ANEURYSM, cl	ipping or reinforcement of sac (Anaes.) (Assist.)			
39800	Fee: \$2,903.25	Benefit: 75% = \$2177.45			
	INTRACRANIA	L ARTERIOVENOUS MALFORMATION, excision of (Anaes.) (Assist.)			
39803	Fee: \$2,903.25	Benefit: 75% = \$2177.45			
	ANEURYSM, or	arteriovenous malformation, intracranial proximal artery clipping of (Anaes.) (Assist.)			
39806	Fee: \$1,306.30	Benefit: 75% = \$979.75			
	INTRACRANIA (Assist.)	L ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.)			
39812	Fee: \$641.85	Benefit: 75% = \$481.40			
	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.)				
39815	Fee: \$1,856.50	Benefit: 75% = \$1392.40 85% = \$1771.80			
	EXTRACRANIA	AL TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist.)			
39818	Fee: \$1,856.50	Benefit: 75% = \$1392.40			
	EXTRACRANIA	AL TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.)			
39821	Fee: \$2,204.45	Benefit: 75% = \$1653.35			
		INFECTION			
	INTRACRANIA	L INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.)			
39900	Fee: \$527.30	Benefit: 75% = \$395.50			
	INTRACRANIA	L ABSCESS, excision of (Anaes.) (Assist.)			
39903	Fee: \$1,612.15	Benefit: 75% = \$1209.15			
	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.)				
39906	Fee: \$809.85	Benefit: 75% = \$607.40			
		CEREBROSPINAL FLUID CIRCULATION DISORDERS			
	VENTRICULO-	CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.)			
40000	Fee: \$932.10	Benefit: 75% = \$699.10			
		EISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.)			
40003					

T8. SUF	RGICAL OPERAT	IONS	7. NEUROSURGIC	
	Fee: \$932.10	Benefit: 75% = \$699.10		
	LUMBAR SHU	NT DIVERSION, insertion of (Anaes.) (Assis	t.)	
40006	Fee: \$733.50	Benefit: 75% = \$550.15		
	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.)			
40009	Fee: \$534.80	Benefit: 75% = \$401.10		
40009			without endoscopic septum	
	THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes.) (Assist.)			
40012	Fee: \$1,046.70	Benefit: 75% = \$785.05		
40012		L DECOMPRESSION (Anaes.) (Assist.)		
1001 -				
40015	Fee: \$648.85	Benefit: 75% = \$486.65	A	
	LUMBAR CERI	EBROSPINAL FLUID DRAIN, insertion of (A	Anaes.)	
40018	Fee: \$161.95	Benefit: 75% = \$121.50 85% = \$137.70		
		CONGENITAL DISORD	ERS	
	MENINGOCEL	E, excision and closure of (Anaes.) (Assist.)		
40100	Fee: \$702.80	Benefit: 75% = \$527.10		
	MYELOMENIN (Anaes.) (Assist.	GOCELE, excision and closure of, including	skin flaps or Z plasty where performed	
40103	Fee: \$1,031.50	Benefit: 75% = \$773.65		
	ARNOLD-CHIA	RI MALFORMATION, decompression of (A	anaes.) (Assist.)	
40106	Fee: \$1,046.70	Benefit: 75% = \$785.05		
10100	ENCEPHALOCOELE, excision and closure of (Anaes.) (Assist.)		st.)	
40100				
40109	Fee: \$1,130.65	Benefit: 75% = \$848.00 RD, release of, including lipomeningocele or	diastomatomyclia (A page) (A ssist)	
	TETHEREDCO	KD, release of, including inpomeningocele of	ulastematomyena (Anaes.) (Assist.)	
40112	Fee: \$1,451.60	Benefit: 75% = \$1088.70		
	CRANIOSTEN	OSIS, operation for - single suture (Anaes.) (A	ssist.)	
40115	Fee: \$733.50	Benefit: 75% = \$550.15		
	CRANIOSTENOSIS, operation for - more than 1 suture (Anaes.) (Assist.)			
40118	Fee: \$970.30	Benefit: 75% = \$727.75		
	SKULL RECONSTRUCTION			
	CRANIOPLASTY, reconstructive (Anaes.) (Assist.)			
40600	Fee: \$970.30	Benefit: 75% = \$727.75		
		EPILEPSY		
	CORPUS CALLOSUM, anterior section of, for epilepsy (Anaes.) (Assist.)			
40700	Fee: \$1,772.55	Benefit: 75% = \$1329.45		
40700		nulation therapy through stimulation of the left	t vanus nerve, subcutaneous placement of	

T8. SUF	GICAL OPERATI	ONS	7. NEUROSURGICAL		
	electrical pulse ge	enerator, for:			
	(a) management of	of refractory generalised epilepsy; or			
	(b) treatment of re	efractory focal epilepsy not suitable for resective	epilepsy surgery (Anaes.) (Assist.)		
	Fee: \$346.05	Benefit: 75% = \$259.55			
		ulation therapy through stimulation of the left vagical pulse generator inserted for:	gus nerve, surgical repositioning or		
	(a) management of	of refractory generalised epilepsy; or			
	(b) treatment of re	efractory focal epilepsy not suitable for resective	epilepsy surgery (Anaes.) (Assist.)		
40702	Fee: \$161.95	Benefit: 75% = \$121.50			
	CORTICECTOM	IY, TOPECTOMY or PARTIAL LOBECTOMY	for epilepsy (Anaes.) (Assist.)		
40703	Fee: \$1,489.75	Benefit: 75% = \$1117.35			
		ulation therapy through stimulation of the left va- tion of lead to left vagus nerve and intra-operative			
	(a) management of	(a) management of refractory generalised epilepsy; or			
	(b) treatment of re	efractory focal epilepsy not suitable for resective	epilepsy surgery (Anaes.) (Assist.)		
40704	Fee: \$684.95	Benefit: 75% = \$513.75			
	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 re	efractory focal epilepsy not suitable for resective	epilepsy surgery (Anaes.) (Assist.)		
40705	Fee: \$615.05	Benefit: 75% = \$461.30			
	HEMISPHEREC	TOMY for intractable epilepsy (Anaes.) (Assist.)			
40706	Fee: \$2,177.40	Benefit: 75% = \$1633.05 85% = \$2092.70			
	-	ulation therapy through stimulation of the left vas vagus nerve stimulation therapy device using exte			
	(a) management of refractory generalised epilepsy; or				
	(b) treatment of re	efractory focal epilepsy not suitable for resective	epilepsy surgery		
40707	Fee: \$192.75	Benefit: 75% = \$144.60 85% = \$163.85			
	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical replacement of battery in electrical pulse generator inserted for:				
	(a) management of refractory generalised epilepsy; or				
	(b) treating refrac	ctory focal epilepsy not suitable for resective epile	epsy surgery (Anaes.) (Assist.)		
40708	Fee: \$346.05	Benefit: 75% = \$259.55			

T8. SUF	RGICAL OPERATIONS 7. NEUROSURGICA			
	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (Anaes.) (Assist.)			
40709	Fee: \$527.30 Benefit: 75% = \$395.50			
	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (Anaes.) (Assist.)			
40712	Fee: \$1,061.90 Benefit: 75% = \$796.45			
	STEREOTACTIC PROCEDURES			
	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (Anaes.) (Assist.)			
40800	Fee: \$648.85 Benefit: 75% = \$486.65 85% = \$564.15			
	FUNCTIONAL STEREOTACTIC procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep white matter tracts, not being a service associated with deep brain stimulation for Parkinson's disease, essential tremo or dystonia (Anaes.) (Assist.)			
40801	Fee: \$1,773.75 Benefit: 75% = \$1330.35			
	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (Anaes.) (Assist.)			
40803	Fee: \$1,214.85 Benefit: 75% = \$911.15 85% = \$1130.15			
	DEEP BRAIN STIMULATION (unilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of:			
	Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or			
	Essential tremor or dystonia where the patient's symptoms cause severe disability (Anaes.) (Assist.)			
40850	Fee: \$2,300.70 Benefit: 75% = \$1725.55			
	DEEP BRAIN STIMULATION (bilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of:			
	Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or			
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.)			
40851	Fee: \$4,026.40 Benefit: 75% = \$3019.80			
	DEEP BRAIN STIMULATION (unilateral) subcutaneous placement of neurostimulator receiver or pulse generator for the treatment of:			
40852	Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or			

T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.) (Assist.)
	Fee: \$346.05 Benefit: 75% = \$259.55	
	DEEP BRAIN STIMULATION (unilateral) revision or removal of brain e	electrode for the treatment of:
	Parkinson's disease where the patient's response to medical therapy is not s by unacceptable motor fluctuations; or	sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.)
40854	Fee: \$534.80 Benefit: 75% = \$401.10	
	DEEP BRAIN STIMULATION (unilateral) removal or replacement of ne generator for the treatment of:	urostimulator receiver or pulse
	Parkinson's disease where the patient's response to medical therapy is not s by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe dis	-
		sability. (Allaes.)
40856	Fee: \$259.55 Benefit: 75% = \$194.70	
	DEEP BRAIN STIMULATION (unilateral) placement, removal or replace the treatment of: Parkinson's disease where the patient's response to medical therapy is not s	
	by unacceptable motor fluctuations; or	-
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.)
40858	Fee: \$534.80 Benefit: 75% = \$401.10	
	DEEP BRAIN STIMULATION (unilateral) target localisation incorporati physiological techniques, including intra-operative clinical evaluation, for neurostimulation wire for the treatment of:	
	Parkinson's disease where the patient's response to medical therapy is not s by unacceptable motor fluctuations; or	sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.)
40860	Fee: \$2,055.05 Benefit: 75% = \$1541.30	
	DEEP BRAIN STIMULATION (unilateral) electronic analysis and progra pulse generator for the treatment of:	amming of neurostimulator
	Parkinson's disease where the patient's response to medical therapy is not s by unacceptable motor fluctuations; or	sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.)
40862	Fee: \$192.75 Benefit: 75% = \$144.60 85% = \$163.85	

T8. SUR	RGICAL OPERATIONS 7. NEUROSURGICA		
	MISCELLANEOUS		
	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.) (Assist.)		
40903	Fee: \$563.40 Benefit: 75% = \$422.55		
	CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.)		
40905	Fee: \$611.35 Benefit: 75% = \$458.55 85% = \$526.65		
T8. SUR	RGICAL OPERATIONS 8. EAR, NOSE AND THROA		
	Group T8. Surgical Operations		
	Subgroup 8. Ear, Nose And Throat		
	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)		
41500	(See para TN.8.72 of explanatory notes to this Category)Fee: $\$83.80$ Benefit: $75\% = \$62.85$ $85\% = \$71.25$		
	Examination of glottal cycles and vibratory characteristics of the vocal folds by a specialist in the practice of the specialist's specialty of otolaryngology using videostroboscopy, including capturing audio, video, frequency and intensity, for confirmation of diagnosis, or for confirmation of treatment effectiveness where there is failure to progress or respond as expected, for:		
	 a. dysphonia where non stroboscopic techniques of the visualising the larynx have failed to identify any frank abnormality of the vocal folds; or b. benign or malignant vocal fold lesions; or c. premalignant or malignant laryngeal lesions; or d. vocal fold motion impairment or glottal insufficiency; or e. evaluation of vocal fold function after treatment or phonosurgery 		
	other than a service associated with a service to which item 41764 applies or with a services associated with the administration of a general anaesthetic		
Amend 41501	(See para TN.8.76 of explanatory notes to this Category) Fee: \$188.55 Benefit: 75% = \$141.45 85% = \$160.30		
	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.)		
41503	Fee: \$242.60 Benefit: 75% = \$181.95 85% = \$206.25		
	AURAL POLYP, removal of (Anaes.)		
41506	Fee: \$146.30 Benefit: 75% = \$109.75 85% = \$124.40		
	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a servic to which another item in this Group applies (Anaes.)		
41509	Fee: \$165.55 Benefit: 75% = \$124.20 85% = \$140.75		
	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.)		
41512	Fee: \$595.25 Benefit: 75% = \$446.45		
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service		

T8. SUF	GICAL OPERATION	ONS 8. EAR, NOSE ANI	8. EAR, NOSE AND THROAT	
	associated with a	service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes	s.) (Assist.)	
	(See para TN.8.73 c Fee: \$390.70	of explanatory notes to this Category) Benefit: 75% = \$293.05		
	EXTERNAL AUI	DITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.)		
41518	Fee: \$943.60	Benefit: 75% = \$707.70		
	Correction of AU (Anaes.) (Assist.)	DITORY CANAL STENOSIS, including meatoplasty, with or without graf	fting	
41521	Fee: \$1,004.65	Benefit: 75% = \$753.50		
		YON OF EXTERNAL AUDITORY CANAL, being a service associated with 557, 41560 and 41563 apply (Anaes.) (Assist.)	ith a service	
41524	(See para TN.8.74 c Fee: \$290.25	of explanatory notes to this Category) Benefit: 75% = \$217.70		
	MYRINGOPLAS	TY, transcanal approach (Rosen incision) (Anaes.) (Assist.)		
41527	Fee: \$597.00	Benefit: 75% = \$447.75		
41527		TTY, postaural or endaural approach with or without mastoid inspection (Ar	naes.)	
41530	Fee: \$972.60	Benefit: 75% = \$729.45		
41550		without reconstruction of the bony defect, with or without myringoplasty (A	Anaes.)	
41533	Fee: \$1,162.60	Benefit: 75% = \$871.95		
		with reconstruction of the bony defect, with or without myringoplasty (Ana	es.) (Assist.)	
41536	Fee: \$1,302.20	Benefit: 75% = \$976.65		
11000		AIN RECONSTRUCTION (Anaes.) (Assist.)		
41539	Fee: \$1,107.35	Benefit: 75% = \$830.55		
11007		AIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.)		
41542	Fee: \$1,213.35	Benefit: 75% = \$910.05		
41342		MY (CORTICAL) (Anaes.) (Assist.)		
11515	Fee: \$529.60	Benefit: 75% = \$397.20		
41545		V OF THE MASTOID CAVITY (Anaes.) (Assist.)		
11510				
41548	Fee: \$702.80	Benefit: 75% = \$527.10 MY, intact wall technique, with myringoplasty (Anaes.) (Assist.)		
41551	Fee: \$1,618.55	Benefit: 75% = \$1213.95		
	(Anaes.) (Assist.)	MY, intact wall technique, with myringoplasty and ossicular chain reconstr	ruction	
41554	Fee: \$1,907.00	Benefit: 75% = \$1430.25		
	MASTOIDECTO	MY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.)		
41557	Fee: \$1,107.35	Benefit: 75% = \$830.55		

T8. SURGICAL OPERATIONS		ONS	8. EAR, NOSE AND THROAT	
	MASTOIDECTO	MY (RADICAL OR MODIFIED RADI	CAL) AND MYRINGOPLASTY (Anaes.)	
41560	Fee: \$1,213.35	Benefit: 75% = \$910.05		
		MY (RADICAL OR MODIFIED RADI AIN RECONSTRUCTION (Anaes.) (As		
41563	Fee: \$1,502.05	Benefit: 75% = \$1126.55		
	CAVITY, BLIND		CAL), OBLITERATION OF THE MASTOID DITORY CANAL AND OBLITERATION	
41564	Fee: \$1,942.40	Benefit: 75% = \$1456.80		
	REVISION OF M (Anaes.) (Assist.)	ASTOIDECTOMY (radical, modified r	adical or intact wall), including myringoplasty	
41566	Fee: \$1,107.35	Benefit: 75% = \$830.55		
	DECOMPRESSIC	N OF FACIAL NERVE in its mastoid	portion (Anaes.) (Assist.)	
41569	Fee: \$1,213.35	Benefit: 75% = \$910.05		
	LABYRINTHOT	OMY OR DESTRUCTION OF LABYR	INTH (Anaes.) (Assist.)	
41572	Fee: \$1,049.75	Benefit: 75% = \$787.35		
	transmastoid, trans		f by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid	
41575	Fee: \$2,474.65	Benefit: 75% = \$1856.00		
	retromastoid appro		of, by transmastoid, translabyrinthine or aftercare) not being a service to which item	
41576	Fee: \$3,712.05	Benefit: 75% = \$2784.05		
		NTINE ANGLE TUMOUR, removal o ach, (intracranial procedure) - conjoint	f, by transmastoid, translabyrinthine or surgery, principal surgeon (Anaes.) (Assist.)	
41578	Fee: \$2,474.65	Benefit: 75% = \$1856.00		
		NTINE ANGLE TUMOUR, removal of bach, (intracranial procedure) - conjoint		
41579	Fee: \$1,856.00	Benefit: 75% = \$1392.00		
	TUMOUR INVOI excision of (Anaes		removal of, involving craniotomy and radical	
41581	Fee: \$2,846.35	Benefit: 75% = \$2134.80		
		DRAL BONE RESECTION for removal ssion of facial nerve (Anaes.) (Assist.)	l of tumour involving mastoidectomy with or	
41584	Fee: \$1,953.40	Benefit: 75% = \$1465.05		
	TOTAL TEMPOR	AL BONE RESECTION for removal o	f tumour (Anaes.) (Assist.)	
41587	Fee: \$2,660.50	Benefit: 75% = \$1995.40		

T8. SUF	SURGICAL OPERATIONS		8. EAR, NOSE AND THROAT	
	ENDOLYMPHA (Anaes.) (Assist.)		DECOMPRESSION with or without drainage of	
41590	Fee: \$1,213.35	Benefit: 75% = \$910.05		
	TRANSLABYRI	NTHINE VESTIBULAR NER	VE SECTION (Anaes.) (Assist.)	
41593	Fee: \$1,581.40	Benefit: 75% = \$1186.05		
	RETROLABYRI BOTH (Anaes.) (VE SECTION or COCHLEAR NERVE SECTION, or	
41596	Fee: \$1,767.35	Benefit: 75% = \$1325.55		
	INTERNAL AU	-	n by middle cranial fossa approach with cranial nerve	
41599	Fee: \$1,767.35	Benefit: 75% = \$1325.55		
		RATION PROCEDURE - impla hearing system device, in patier	ntation of titanium fixture for use with implantable nts:	
	- With a perma	nent or long term hearing loss;	and	
	- Unable to util and	ise conventional air or bone cor	nduction hearing aid for medical or audiological reasons;	
	- With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted.			
	Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.)			
41603	Fee: \$511.90	Benefit: 75% = \$383.95 85	% = \$435.15	
	OSSEO-INTEGRATION PROCEDURE - fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients:			
	- With a permanent or long term hearing loss; and			
	- Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and			
	- With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted.			
	Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.)			
41604	Fee: \$189.50	Benefit: 75% = \$142.15 85	% = \$161.10	
		MY (Anaes.) (Assist.)		
	Fee: \$1,107.35	Benefit: 75% = \$830.55		
41608	I'CC. 01.107.00	STAPES MOBILISATION (Anaes.) (Assist.)		
41608				
	STAPES MOBIL	LISATION (Anaes.) (Assist.)		
41608 41611	STAPES MOBIL Fee: \$712.50	LISATION (Anaes.) (Assist.) Benefit: 75% = \$534.40	r of cochleotomy (Anaes.) (Assist.)	
	STAPES MOBIL Fee: \$712.50	LISATION (Anaes.) (Assist.) Benefit: 75% = \$534.40	r of cochleotomy (Anaes.) (Assist.)	

T8. SUF	SURGICAL OPERATIONS	8. EAR, NOSE AND THROAT	
	to which any other item in this Group applies (Anaes.) (Assist.)		
	Fee: \$1,107.35 Benefit: 75% = \$830.55 85% = \$1022.65		
	COCHLEAR IMPLANT, insertion of, including mastoidectomy (A	anaes.) (Assist.)	
41617	Fee: \$1,925.50 Benefit: 75% = \$1444.15		
	Middle ear implant, partially implantable, insertion of, via mastoide	ectomy, for patients with:	
	(a) stable sensorineural hearing loss; and		
	(b) outer ear pathology that prevents the use of a conventional hear	ing aid; and	
	(c) a PTA4 of less than 80 dBHL; and		
	(d) bilateral, symmetrical hearing loss with PTA thresholds in both each other; and	ears within 20 dBHL (0.5-4kHz) of	
	(e) speech perception discrimination of at least 65% correct for wor sound; and	rd lists with appropriately amplified	
	(f) a normal middle ear; and		
	(g) normal tympanometry; and		
	(h) on audiometry, an air-bone gap of less than 10 dBHL (0.5-4kHz) across all frequencies; and		
	(i) no other inner ear disorders		
	(Anaes.) (Assist.)		
41618	Fee: \$1,907.00 Benefit: 75% = \$1430.25		
	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.)		
41620	Fee: \$837.75 Benefit: 75% = \$628.35		
	GLOMUS TUMOUR, transmastoid removal of, including mastoide	ectomy (Anaes.) (Assist.)	
41623	Fee: \$1,213.35 Benefit: 75% = \$910.05		
	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for	or (excluding aftercare) (Anaes.)	
11.000	(See para TN.8.4 of explanatory notes to this Category)		
41626	Fee: \$146.30 Benefit: 75% = \$109.75 85% = \$124.40 MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.)		
41629			
41629	Fee: \$529.60 Benefit: 75% = \$397.20 MIDDLE EAR, insertion of tube for DRAINAGE OF (including m	vringotomy) (Anaes)	
41632		<u>6</u>	
41632	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLES	STEATOMA and POLYP 1 or more	
	with or without myringoplasty (Anaes.) (Assist.)		
41635	Fee: \$1,162.60 Benefit: 75% = \$871.95 85% = \$1077.90		
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLES	STEATOMA and POLYP, 1 or more,	

T8. SUF	GICAL OPERAT	IONS	8. EAR, NOSE AND THROAT
	with or without	myringoplasty with ossicular chain re	econstruction (Anaes.) (Assist.)
	Fee: \$1,451.20	Benefit: 75% = \$1088.40	
	PERFORATION	NOF TYMPANUM, cauterisation or	diathermy of (Anaes.)
41641	Fee: \$48.20	Benefit: 75% = \$36.15 85% = \$4	41.00
	EXCISION OF myringoplasty (A		N, not being a service associated with
41644	Fee: \$145.10	Benefit: 75% = \$108.85 85% = \$	\$123.35
		equiring use of operating microscope al anaesthesia (Anaes.)	and microinspection of tympanic membrane with
41647	Fee: \$111.65	Benefit: 75% = \$83.75 85% = \$	94.95
		EMBRANE, microinspection of 1 or ad with a service to which another iter	both ears under general anaesthesia, not being a m in this Group applies (Anaes.)
41650	Fee: \$111.65	Benefit: 75% = \$83.75 85% = \$	94.95
	POSTNASAL S		SAL SPACE, or NASAL CAVITY AND STHESIA, not being a service associated with a Anaes.)
41653	Fee: \$73.10	Benefit: 75% = \$54.85 85% = \$6	52 15
	NASAL HAEM		GOF, with posterior nasal packing with or without
41656	·	of explanatory notes to this Category)	107.10
41656	Fee: \$124.80	Benefit: 75% = \$93.60 85% = \$ of FOREIGN BODY IN, other than	
41659	Fee: \$78.80	Benefit: 75% = \$59.10 85% = \$	
		OR POLYPI (SIMPLE), removal of	
41662	(See para TN.8.75 Fee: \$83.80	of explanatory notes to this Category) Benefit: 75% = \$62.85 85% = \$'	71.25
		POR POLYPI, removal of (Anaes.)	
41668	(See para TN.8.75 Fee: \$223.45	of explanatory notes to this Category) Benefit: 75% = \$167.60	
	NASAL SEPTU (Anaes.)	M, SEPTOPLASTY, SUBMUCOUS	S RESECTION or closure of septal perforation
41671	(See para TN.8.10 Fee: \$491.00	4 of explanatory notes to this Category) Benefit: 75% = \$368.25	
	NASAL SEPTU	M, reconstruction of (Anaes.) (Assist	 t.)
41672	Fee: \$612.50	Benefit: 75% = \$459.40	
41674	general anaesthe	sia or diathermy of septum or turbina	erisation by chemical means when performed under ates—one or more of these procedures (including ervice associated with another operation on the

GICAL OPERATI	ONS 8. EAR, NOSE AND THROAT
nose (Anaes.)	
Fee: \$102.10	Benefit: 75% = \$76.60 85% = \$86.80
NASAL HAEMO packing or both (.	DRRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity Anaes.)
Fee: \$91.45	Benefit: 75% = \$68.60 85% = \$77.75
	ASAL ADHESIONS, with or without stenting not being a service associated with any n the nose and not performed during the postoperative period of a nasal operation
Fee: \$119.10	Benefit: 75% = \$89.35 85% = \$101.25
	OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated which another item in this Group applies (Anaes.)
Fee: \$73.10	Benefit: 75% = \$54.85 85% = \$62.15
TURBINECTON	IY or turbinectomies, partial or total, unilateral (Anaes.)
Fee: \$138.70	Benefit: 75% = \$104.05
TURBINATES, s	submucous resection of, unilateral (Anaes.)
Fee: \$180.90	Benefit: 75% = \$135.70
MAXILLARY A	NTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.)
Fee: \$33.05	Benefit: 75% = \$24.80 85% = \$28.10
MAXILLARY A	NTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission eing a service associated with a service to which another item in this Group applies
Fee: \$93.35	Benefit: 75% = \$70.05
	NTRUM, LAVAGE OF each attendance at which the procedure is performed, ociated consultation (Anaes.)
Fee: \$36.90	Benefit: 75% = \$27.70 85% = \$31.40
MAXILLARY A	RTERY, transantral ligation of (Anaes.) (Assist.)
Fee: \$455.75	Benefit: 75% = \$341.85
ANTROSTOMY	(RADICAL) (Anaes.) (Assist.)
Fee: \$529.60	Benefit: 75% = \$397.20
ANTROSTOMY (Anaes.) (Assist.)	(RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy
Fee: \$616.20	Benefit: 75% = \$462.15
ANTRUM, intrar	nasal operation on, or removal of foreign body from (Anaes.) (Assist.)
Fee: \$300.45	Benefit: 75% = \$225.35
	age of, through tooth socket (Anaes.)
Fee: \$119.45	Benefit: 75% = \$89.60 85% = \$101.55
	 nose (Anaes.) Fee: \$102.10 NASAL HAEMO packing or both (anaes.) Fee: \$91.45 DIVISION OF N other operation of (Anaes.) Fee: \$119.10 DISLOCATION with a service to an Fee: \$138.70 TURBINECTOM Fee: \$138.70 TURBINATES, and Fee: \$180.90 MAXILLARY A Fee: \$33.05 MAXILLARY A Fee: \$93.35 MAXILLARY A including any ass Fee: \$36.90 MAXILLARY A Fee: \$36.90 MAXILLARY A Fee: \$36.90 MAXILLARY A Fee: \$36.90 MAXILLARY A Fee: \$529.60 ANTROSTOMY (Anaes.) (Assist.) Fee: \$616.20 ANTRUM, intrar Fee: \$300.45

T8. SUF	GICAL OPERAT	ONS 8. EAR, NOSE AND THROA
	OROANTRAL	ISTULA, plastic closure of (Anaes.) (Assist.)
41722	Fee: \$597.00	Benefit: 75% = \$447.75 85% = \$512.30
	ETHMOIDAL A	RTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.)
41725	Fee: \$455.75	Benefit: 75% = \$341.85
	LATERAL RHI	NOTOMY with removal of tumour (Anaes.) (Assist.)
41728	Fee: \$911.65	Benefit: 75% = \$683.75
	DERMOID OF	JOSE, excision of, with intranasal extension (Anaes.) (Assist.)
41729	Fee: \$577.75	Benefit: 75% = \$433.35
	FRONTONASA (Assist.)	L ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.
41731	Fee: \$789.55	Benefit: 75% = \$592.20
	RADICAL FRO	NTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.)
41734	Fee: \$1,030.25	Benefit: 75% = \$772.70
	FRONTAL SIN (Anaes.) (Assist	JS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on
41737	Fee: \$491.00	Benefit: 75% = \$368.25
	FRONTAL SIN	JS, catheterisation of (Anaes.)
41740	Fee: \$59.75	Benefit: 75% = \$44.85
	FRONTAL SIN	JS, trephine of (Anaes.) (Assist.)
41743	Fee: \$342.85	Benefit: 75% = \$257.15
	FRONTAL SIN	JS, radical obliteration of (Anaes.) (Assist.)
41746	Fee: \$789.55	Benefit: 75% = \$592.20 85% = \$704.85
	ETHMOIDAL S	INUSES, external operation on (Anaes.) (Assist.)
41749	Fee: \$616.20	Benefit: 75% = \$462.15
	SPHENOIDAL	SINUS, intranasal operation on (Anaes.) (Assist.)
41752	Fee: \$300.45	Benefit: 75% = \$225.35
	EUSTACHIAN	ΓUBE, catheterisation of (Anaes.)
41755	Fee: \$47.25	Benefit: 75% = \$35.45 85% = \$40.20
		PY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and r more of these procedures, unilateral or bilateral examination (Anaes.)
41764	Fee: \$124.80	Benefit: 75% = \$93.60 85% = \$106.10
	NASOPHARYN	GEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.)
41767	Fee: \$748.80	Benefit: 75% = \$561.60 85% = \$664.10
41770	PHARYNGEAI	POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.)

T8. SUF	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT
	Fee: \$712.50	Benefit: 75% = \$534.40
	PHARYNGEAL	POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.)
41773	Fee: \$597.00	Benefit: 75% = \$447.75
	CRICOPHARY	NGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.)
41776	Fee: \$595.25	Benefit: 75% = \$446.45
11770	-	DMY (lateral), with or without total excision of tongue (Anaes.) (Assist.)
41779	Fee: \$712.50	Benefit: 75% = \$534.40
+1///		RYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.)
41700		
41782	Fee: \$967.35	Benefit: 75% = \$725.55 85% = \$882.65
	(Assist.)	RYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.)
41785	Fee: \$1,200.05	Benefit: 75% = \$900.05
	UVULOPALAT (Assist.)	OPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.)
41786	Fee: \$748.80	Benefit: 75% = \$561.60
		(AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, onsillectomy, 1 or more stages, including any revision procedures within 12 months)
41787	Fee: \$577.75	Benefit: 75% = \$433.35 85% = \$493.05
	examination of t	s and adenoids, removal of, in a person aged less than 12 years (including any he postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies
	(Anaes.)	
41789	Fee: \$300.45	Benefit: 75% = \$225.35
	examination of t	s and adenoids, removal of, in a person 12 years of age or over (including any he postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies (Anaes.)
41702	Fee: \$377.45	Benefit: 75% = \$283.10
41/93		
41793		ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general owing removal of (Anaes.)
41793 41797	anaesthesia, follo Fee: \$146.30 Adenoids, remov	owing removal of (Anaes.)
	anaesthesia, follo Fee: \$146.30 Adenoids, remov	wing removal of (Anaes.) Benefit: 75% = \$109.75 val of (including any examination of the postnasal space and nasopharynx and the
41797	anaesthesia, follo Fee: \$146.30 Adenoids, removinfiltration of loc Fee: \$165.55	Benefit: 75% = \$109.75 val of (including any examination of the postnasal space and nasopharynx and the cal anaesthetic), not being a service to which item 41764 applies (Anaes.)

AND THROAT
es.) (Assist.)
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CONTINUITY
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T8. SUF	RGICAL OPERAT	ONS 8. EAR, NOSE AND THRO	ЭАТ
	Fee: \$613.95	Benefit: 75% = \$460.50	
	MICROLARYN	GOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.)	
41864	Fee: \$414.00	Benefit: 75% = \$310.50	
	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.)		
41867	Fee: \$623.20	Benefit: 75% = \$467.40	
	LARYNGEAL	VEB, division of, using microlarygoscopic techniques (Anaes.)	
41868	Fee: \$394.90	Benefit: 75% = \$296.20	
		VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assis	st.)
41870	Fee: \$462.15	Benefit: 75% = \$346.65	
11070		CTURED, operation for (Anaes.) (Assist.)	
41873	Fee: \$597.00	Benefit: 75% = \$447.75 85% = \$512.30	
410/3		hal operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.)	
	(Assist.)		
41876	Fee: \$597.00	Benefit: 75% = \$447.75 85% = \$512.30	
	LARYNGOPLA	STY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.)	
41879	Fee: \$967.35	Benefit: 75% = \$725.55	
		MY by a percutaneous technique using sequential dilatation or partial splitting metho of a cuffed tracheostomy tube (Anaes.)	od
41880	Fee: \$258.20	Benefit: 75% = \$193.65	
		MY by open exposure of the trachea, including separation of the strap muscles or yroid isthmus, where performed (Anaes.) (Assist.)	
41881	Fee: \$408.20	Benefit: 75% = \$306.15	
	CRICOTHYRO	TOMY by direct stab or Seldinger technique, using mini tracheostomy device (Ana	es.)
41884	Fee: \$92.50	Benefit: 75% = \$69.40	
		PHAGEAL FISTULA, formation of, as a secondary procedure following cluding associated endoscopic procedures (Anaes.) (Assist.)	
41885	Fee: \$292.50	Benefit: 75% = \$219.40 85% = \$248.65	
	TRACHEA, rem	oval of foreign body in (Anaes.)	
41886	Fee: \$180.90	Benefit: 75% = \$135.70 85% = \$153.80	
	BRONCHOSCO	PY, as an independent procedure (Anaes.)	
41889	Fee: \$180.90	Benefit: 75% = \$135.70 85% = \$153.80	
		PY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedu	ures
41892	Fee: \$238.80	Benefit: 75% = \$179.10 85% = \$203.00	
41895		moval of foreign body in (Anaes.) (Assist.)	

	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT
	Fee: \$373.65	Benefit: 75% = \$280.25
		RONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without achoalveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.)
41898	Fee: \$261.05	Benefit: 75% = \$195.80 85% = \$221.90
		LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction sociated endoscopic procedures (Anaes.) (Assist.)
41901	Fee: \$613.95	Benefit: 75% = \$460.50
	BRONCHOSCO	PY with dilatation of tracheal stricture (Anaes.)
41904	Fee: \$250.45	Benefit: 75% = \$187.85 85% = \$212.90
	TRACHEA OR	BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.)
41905	Fee: \$460.60	Benefit: 75% = \$345.45
	NASAL SEPTU	M BUTTON, insertion of (Anaes.)
41907	Fee: \$124.80	Benefit: 75% = \$93.60 85% = \$106.10
	DUCT OF MAJ	OR SALIVARY GLAND, transposition of (Anaes.) (Assist.)
41910	Fee: \$396.50	Benefit: 75% = \$297.40
T8. SU	RGICAL OPERAT	
		IONS 9. OPHTHALMOLOGI
	Group T8. Surgi	cal Operations
	Group T8. Surgi	cal Operations Subgroup 9. Ophthalmology
	Group T8. Surgi	cal Operations
42503	Group T8. Surgi	cal Operations Subgroup 9. Ophthalmology OGICAL EXAMINATION under general anaesthesia, not being a service associated
	Group T8. Surgi OPHTHALMOL with a service to Fee: \$104.15 Complete remov	Subgroup 9. Ophthalmology COGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.) Benefit: 75% = \$78.15 al from the eye of a trans-trabecular drainage device or devices, with or without
42503	Group T8. Surgi OPHTHALMOL with a service to Fee: \$104.15 Complete remov replacement, foll Fee: \$305.55	Subgroup 9. Ophthalmology COGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.) Benefit: 75% = \$78.15 al from the eye of a trans-trabecular drainage device or devices, with or without
42503	Group T8. Surgi OPHTHALMOL with a service to Fee: \$104.15 Complete remov replacement, foll Fee: \$305.55 Extended Medie	Subgroup 9. Ophthalmology COGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.) Benefit: 75% = \$78.15 al from the eye of a trans-trabecular drainage device or devices, with or without owing device related medical complications necessitating complete removal. (Anaes.) Benefit: 75% = \$229.20 85% = \$259.75
42503	Group T8. Surgi OPHTHALMOL with a service to Fee: \$104.15 Complete remov replacement, foll Fee: \$305.55 Extended Medie	Subgroup 9. Ophthalmology .OGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.) Benefit: 75% = \$78.15 al from the eye of a trans-trabecular drainage device or devices, with or without owing device related medical complications necessitating complete removal. (Anaes.) Benefit: 75% = \$229.20 B5% = \$259.75 Care Safety Net Cap: \$45.85
42503	Group T8. Surgi OPHTHALMOL with a service to Fee: \$104.15 Complete remove replacement, foll Fee: \$305.55 Extended Media EYE, ENUCLEA Fee: \$488.95	cal Operations Subgroup 9. Ophthalmology .OGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.) Benefit: 75% = \$78.15 al from the eye of a trans-trabecular drainage device or devices, with or without owing device related medical complications necessitating complete removal. (Anaes.) Benefit: 75% = \$229.20 B5% = \$259.75 Care Safety Net Cap: \$45.85 ATION OF, with or without sphere implant (Anaes.) (Assist.)
42503 42505 42506	Group T8. Surgi OPHTHALMOL with a service to Fee: \$104.15 Complete remove replacement, foll Fee: \$305.55 Extended Media EYE, ENUCLEA Fee: \$488.95	Subgroup 9. Ophthalmology OGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.) Benefit: 75% = \$78.15 al from the eye of a trans-trabecular drainage device or devices, with or without owing device related medical complications necessitating complete removal. (Anaes.) Benefit: 75% = \$229.20 B5% = \$259.75 Care Safety Net Cap: \$45.85 ATION OF, with or without sphere implant (Anaes.) (Assist.) Benefit: 75% = \$366.75 B5% = \$415.65
	Group T8. Surgi OPHTHALMOL with a service to Fee: \$104.15 Complete remov replacement, foll Fee: \$305.55 Extended Media EYE, ENUCLEA Fee: \$488.95 EYE, ENUCLEA Fee: \$618.80	Subgroup 9. Ophthalmology COGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.) Benefit: 75% = \$78.15 al from the eye of a trans-trabecular drainage device or devices, with or without owing device related medical complications necessitating complete removal. (Anaes.) Benefit: 75% = \$229.20 B5% = \$259.75 Care Safety Net Cap: \$45.85 ATION OF, with or without sphere implant (Anaes.) (Assist.) Benefit: 75% = \$366.75 ATION OF, with insertion of integrated implant (Anaes.) (Assist.)
42503 42505 42506	Group T8. Surgi OPHTHALMOL with a service to Fee: \$104.15 Complete remov replacement, foll Fee: \$305.55 Extended Media EYE, ENUCLEA Fee: \$488.95 EYE, ENUCLEA Fee: \$618.80 EYE, enucleation	Subgroup 9. Ophthalmology OGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.) Benefit: 75% = \$78.15 al from the eye of a trans-trabecular drainage device or devices, with or without owing device related medical complications necessitating complete removal. (Anaes.) Benefit: 75% = \$229.20 85% = \$259.75 care Safety Net Cap: \$45.85 ATION OF, with or without sphere implant (Anaes.) (Assist.) Benefit: 75% = \$366.75 85% = \$415.65 ATION OF, with insertion of integrated implant (Anaes.) (Assist.) Benefit: 75% = \$464.10
42503 42505 42506 42509	Group T8. Surgi OPHTHALMOL with a service to Fee: \$104.15 Complete remov replacement, foll Fee: \$305.55 Extended Media EYE, ENUCLEA Fee: \$488.95 EYE, ENUCLEA Fee: \$618.80 EYE, enucleation (Assist.) Fee: \$713.30	Subgroup 9. Ophthalmology OGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.) Benefit: 75% = \$78.15 al from the eye of a trans-trabecular drainage device or devices, with or without owing device related medical complications necessitating complete removal. (Anaes.) Benefit: 75% = \$229.20 85% = \$259.75 care Safety Net Cap: \$45.85 ATION OF, with or without sphere implant (Anaes.) (Assist.) Benefit: 75% = \$366.75 85% = \$415.65 ATION OF, with insertion of integrated implant (Anaes.) (Assist.) Benefit: 75% = \$464.10 n of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.)
42503 42505 42506 42509	Group T8. Surgi OPHTHALMOL with a service to Fee: \$104.15 Complete remov replacement, foll Fee: \$305.55 Extended Media EYE, ENUCLEA Fee: \$488.95 EYE, ENUCLEA Fee: \$618.80 EYE, enucleation (Assist.) Fee: \$713.30	Subgroup 9. Ophthalmology OGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.) Benefit: 75% = \$78.15 al from the eye of a trans-trabecular drainage device or devices, with or without owing device related medical complications necessitating complete removal. (Anaes.) Benefit: 75% = \$229.20 BS5% = \$259.75 Care Safety Net Cap: \$45.85 ATION OF, with or without sphere implant (Anaes.) (Assist.) Benefit: 75% = \$366.75 BENEfit: 75% = \$366.75 AS5% = \$415.65 ATION OF, with insertion of integrated implant (Anaes.) (Assist.) Benefit: 75% = \$464.10 n of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) Benefit: 75% = \$535.00

T8. SUF	RGICAL OPERATIO	DNS	9. OPHTHALMOLOGY
	(Anaes.) (Assist.)		
	Fee: \$618.80	Benefit: 75% = \$464.10	
	procedure, or REN	C ORBIT, INSERTION OF CARTILAGE MOVAL OF IMPLANT FROM SOCKET, o PEG by drilling into an existing orbital impla	PLACEMENT OF A MOTILITY
42518	Fee: \$359.00	Benefit: 75% = \$269.25	
		C SOCKET, treatment of, by insertion of a a secondary procedure (Anaes.) (Assist.)	wired-in conformer, integrated implant or
42521	Fee: \$1,222.45	Benefit: 75% = \$916.85	
	ORBIT, SKIN GR	AFT TO, as a delayed procedure (Anaes.)	
42524	Fee: \$207.85	Benefit: 75% = \$155.90 85% = \$176.70	
		SOCKET, RECONSTRUCTION INCLUDI ULD (Anaes.) (Assist.)	NG MUCOUS MEMBRANE GRAFTING
42527	Fee: \$412.55	Benefit: 75% = \$309.45	
	ORBIT, EXPLOR	ATION with or without biopsy, requiring R	EMOVAL OF BONE (Anaes.) (Assist.)
42530	Fee: \$641.85	Benefit: 75% = \$481.40	
	ORBIT, EXPLOR	ATION OF, with drainage or biopsy not req	quiring removal of bone (Anaes.) (Assist.)
42533	Fee: \$412.55	Benefit: 75% = \$309.45	
	ORBIT, EXENTE transplant (Anaes.	RATION OF, with or without skin graft and) (Assist.)	d with or without temporalis muscle
42536	Fee: \$847.95	Benefit: 75% = \$636.00	
	ORBIT, EXPLOR (Anaes.) (Assist.)	ATION OF, with removal of tumour or fore	eign body, requiring removal of bone
42539	Fee: \$1,207.20	Benefit: 75% = \$905.40	
	ORBIT, exploration	on of anterior aspect with removal of tumour	r or foreign body (Anaes.) (Assist.)
42542	Fee: \$511.90	Benefit: 75% = \$383.95	
	ORBIT, exploration	on of retrobulbar aspect with removal of turn	nour or foreign body (Anaes.) (Assist.)
42543	Fee: \$898.00	Benefit: 75% = \$673.50	
	· 1	ession of, for dysthyroid eye disease, by fene bital peribulbar and retrobulbar fat from eac	
42545	Fee: \$1,298.80	Benefit: 75% = \$974.10	
	OPTIC NERVE M	IENINGES, incision of (Anaes.) (Assist.)	
42548	Fee: \$771.55	Benefit: 75% = \$578.70	
	EYE, PENETRAT	TING WOUND OR RUPTURE OF, not invo	
	involving suture o (Assist.)	f cornea or sclera, or both, not being a servic	ce to which item 42632 applies (Anaes.)
42551	(100101.)		

T8. SUF	RGICAL OPERATI	ONS	9. OPHTHALMOLOGY
	Fee: \$641.85	Benefit: 75% = \$481.40 85% = \$557.15	
	EYE, PENETRA repair (Anaes.) (A	TING WOUND OR RUPTURE OF, with incarcera	ation or prolapse of uveal tissue
42554	Fee: \$748.80	Benefit: 75% = \$561.60	
	EYE, PENETRA (Anaes.) (Assist.)	TING WOUND OR RUPTURE OF, with incarcera	ation of lens or vitreous repair
42557	Fee: \$1,046.70	Benefit: 75% = \$785.05	
	INTRAOCULAR	FOREIGN BODY, removal from anterior segmen	tt (Anaes.) (Assist.)
42563	Fee: \$527.30	Benefit: 75% = \$395.50 85% = \$448.25	
	INTRAOCULAR	FOREIGN BODY, removal from posterior segme	ent (Anaes.) (Assist.)
42569	Fee: \$1,046.70	Benefit: 75% = \$785.05	
	ORBITAL ABSC	ESS OR CYST, drainage of (Anaes.)	
42572	Fee: \$119.25	Benefit: 75% = \$89.45 85% = \$101.40	
		orbital, excision of, on a person 10 years of age or o	over (Anaes.)
42573	Fee: \$231.10	Benefit: 75% = \$173.35 85% = \$196.45	
12070		al, excision of (Anaes.) (Assist.)	
42574	Fee: \$491.00	Benefit: 75% = \$368.25 85% = \$417.35	
42374		extirpation of (Anaes.)	
10575		-	
42575	Fee: \$84.05	Benefit: $75\% = 63.05 $85\% = 71.45 orbital, excision of, on a person under 10 years of a	ge (Anaes)
			50 (1 maos.)
42576	Fee: \$300.45	Benefit: 75% = \$225.35 85% = \$255.40	
	ECTROPION OF	R ENTROPION, tarsal cauterisation of (Anaes.)	
42581	Fee: \$119.25	Benefit: 75% = \$89.45 85% = \$101.40	
	TARSORRHAPH	IY (Anaes.) (Assist.)	
42584	Fee: \$281.25	Benefit: 75% = \$210.95 85% = \$239.10	
	TRICHIASIS (du each eyelid (Anae	e to causes other than trachoma), treatment of by cases.)	ryotherapy, laser or electrolysis -
42587	Fee: \$52.80	Benefit: 75% = \$39.60 85% = \$44.90	
	TRICHIASIS (du	e to trachoma), treatment of by cryotherapy, laser of	or electrolysis - each eyelid (Anaes.)
42588	Fee: \$52.80	Benefit: 75% = \$39.60 85% = \$44.90	
	CANTHOPLAST	Y, medial or lateral (Anaes.) (Assist.)	
42590	Fee: \$343.75 Extended Medic	Benefit: 75% = \$257.85 85% = \$292.20 are Safety Net Cap: \$275.00	
		AND, excision of palpebral lobe (Anaes.)	
42593	Fee: \$207.85	Benefit: 75% = \$155.90	
12373	Ξ - φ207.05	$\psi_{1,0,0} = \psi_{1,0,0,0}$	

T8. SUF	GICAL OPERATI	ONS		9. OPHTHALMOLOGY
	LACRIMAL SA	C, excision of, or operation of	on (Anaes.) (Assist.)	
42596	Fee: \$511.90	Benefit: 75% = \$383.95	85% = \$435.15	
		NALICULAR SYSTEM, est 1 eye (Anaes.) (Assist.)	tablishment of patency by closed	operation using silicone
42599	Fee: \$641.85	Benefit: 75% = \$481.40	85% = \$557.15	
	LACRIMAL CA (Assist.)	NALICULAR SYSTEM, est	tablishment of patency by open of	peration, 1 eye (Anaes.)
42602	Fee: \$641.85	Benefit: 75% = \$481.40	85% = \$557.15	
	LACRIMAL CA	NALICULUS, immediate re	pair of (Anaes.) (Assist.)	
42605	Fee: \$473.55	Benefit: 75% = \$355.20	85% = \$402.55	
	LACRIMAL DR	AINAGE by insertion of glas	ss tube, as an independent proced	ure (Anaes.) (Assist.)
42608	Fee: \$305.55	Benefit: 75% = \$229.20	85% = \$259.75	
			val or replacement of, or LACRIN thout lavage - under general anae	
42610	Fee: \$97.80	Benefit: 75% = \$73.35	85% = \$83.15	
			al or replacement of, or LACRIM ge - under general anaesthesia (A	
42611	Fee: \$146.65	Benefit: 75% = \$110.00	85% = \$124.70	
	probing to establi	sh patency of the lacrimal pa	val or replacement of, or LACRIN assage and/or site of obstruction, service to which item 42610 appli	unilateral, including
42614	(See para TN.8.4 o Fee: \$49.05	f explanatory notes to this Categ Benefit: 75% = \$36.80		
	to establish paten	cy of the lacrimal passage ar	al or replacement of, or LACRIM nd/or site of obstruction, bilateral, hich item 42611 applies (excludir	including lavage, not
42615	Fee: \$73.40	Benefit: 75% = \$55.05	85% = \$62.40	
	PUNCTUM SNI	P operation (Anaes.)		
42617	Fee: \$139.15	Benefit: 75% = \$104.40	85% = \$118.30	
	PUNCTUM, occ	lusion of, by use of a plug (A	Anaes.)	
42620	Fee: \$53.50	Benefit: 75% = \$40.15	85% = \$45.50	
			of electrical cautery (Anaes.)	
42622	Fee: \$84.05	Benefit: 75% = \$63.05	85% = \$71.45	
		ORHINOSTOMY (Anaes.) (
42623	Fee: \$710.65	Benefit: 75% = \$533.00		
		ORHINOSTOMY where a p	revious dacryocystorhinostomy h	as been performed
42626				

T8. SUF	RGICAL OPERATIC	ONS		9. OPHTHALMOLOGY
	Fee: \$1,146.10	Benefit: 75% = \$859.6	0 85% = \$1061.40	
	CONJUNCTIVOR (Anaes.) (Assist.)	RHINOSTOMY including	g dacryocystorhinostomy and fash	ioning of conjunctival flaps
42629	Fee: \$863.30	Benefit: 75% = \$647.5	0	
	CONJUNCTIVAL (Anaes.)	PERITOMY OR REPA	IR OF CORNEAL LACERATIO	N by conjunctival flap
42632	Fee: \$119.25	Benefit: 75% = \$89.45	85% = \$101.40	
	CORNEAL PERF	ORATIONS, sealing of,	with tissue adhesive (Anaes.) (As	sist.)
42635	Fee: \$305.55	Benefit: 75% = \$229.2	0 85% = \$259.75	
	CONJUNCTIVAL	GRAFT OVER CORNI	EA (Anaes.) (Assist.)	
42638	Fee: \$382.00	Benefit: 75% = \$286.5	0 85% = \$324.70	
	AUTOCONJUNC	TIVAL TRANSPLANT,	or mucous membrane graft (Ana	es.) (Assist.)
42641	Fee: \$496.55	Benefit: 75% = \$372.4	5 85% = \$422.10	
		LERA, complete remova me practitioner (excludin	l of embedded foreign body from ng aftercare) (Anaes.)	- not more than once on the
42644	(See para TN.8.78, T Fee: \$73.30	N.8.4 of explanatory notes Benefit: 75% = \$55.00		
	CORNEAL SCAR which item 42686	• •	keratectomy, not being a service	associated with a service to
42647	Fee: \$207.85	Benefit: 75% = \$155.9	0 85% = \$176.70	
	CORNEA, epitheli	ial debridement for corne	eal ulcer or corneal erosion (exclue	ding aftercare) (Anaes.)
42650	(See para TN.8.4 of Fee: \$73.30	explanatory notes to this Ca Benefit: 75% = \$55.00		
	CORNEA, epitheli	ial debridement for elimi	nating band keratopathy (Anaes.)	
42651	Fee: \$163.35	Benefit: 75% = \$122.5	5 85% = \$138.85	
	Corneal collagen c progression—per e	• 1	with a corneal ectatic disorder, w	ith evidence of
42652	(See para TN.8.136 o Fee: \$1,219.20	of explanatory notes to this Benefit: 75% = \$914.4		
	CORNEA transpla	ntation of (Anaes.) (Assi	st.)	
42653	Fee: \$1,328.65	Benefit: 75% = \$996.5	0	
		antation of, second and s	ubsequent procedures (Anaes.) (A	ssist.)
42656	Fee: \$1,696.15	Benefit: 75% = \$1272.	15	
			, including collection of donor ma	terial (Anaes.) (Assist.)
42662	Fee: \$916.75	Benefit: 75% = \$687.6	-	
72002			lamellar, including collection of c	lonor material (Anaes.)
42665	(1.00101.)			

T8. SUF	RGICAL OPERAT	ONS 9. OPHTHALMOLOGY
	Fee: \$611.30	Benefit: 75% = \$458.50 85% = \$526.60
		NEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to m where a reduction of 2 dioptres of astigmatism is obtained, including any associated
42667	Fee: \$144.20	Benefit: 75% = \$108.15 85% = \$122.60
	CORNEAL SU	URES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or cope (Anaes.)
42668	Fee: \$76.50	Benefit: 75% = \$57.40 85% = \$65.05
		SONS, to correct corneal astigmatism of more than $1^{1/2}$ dioptres following anterior including appropriate measurements and calculations, performed as an independent .) (Assist.)
42672	(See para TN.8.79 Fee: \$916.75	of explanatory notes to this Category) Benefit: 75% = \$687.60 85% = \$832.05
	including approp	CORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1/2}$ dioptres, riate measurements and calculations, performed in conjunction with other anterior (Anaes.) (Assist.)
42673	Fee: \$458.30	Benefit: 75% = \$343.75 85% = \$389.60
	CONJUNCTIV	, biopsy of, as an independent procedure
42676	Fee: \$117.55	Benefit: 75% = \$88.20 85% = \$99.95
		, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at s given including any associated consultation (Anaes.)
42677	Fee: \$61.95	Benefit: 75% = \$46.50 85% = \$52.70
	CONJUNCTIV	, cryotherapy to, for melanotic lesions or similar using CO ² or N ² 0 (Anaes.)
42680	Fee: \$305.55	Benefit: 75% = \$229.20 85% = \$259.75
	CONJUNCTIVA (Anaes.)	L CYSTS, removal of, requiring admission to hospital or approved day-hospital facility
42683	Fee: \$122.30	Benefit: 75% = \$91.75
	PTERYGIUM, 1	emoval of (Anaes.)
42686	Fee: \$278.05	Benefit: 75% = \$208.55 85% = \$236.35
	PINGUECULA	removal of, not being a service associated with the fitting of contact lenses (Anaes.)
42689	Fee: \$119.25	Benefit: 75% = \$89.45 85% = \$101.40
		JR, removal of, excluding Pterygium (Anaes.) (Assist.)
42692	Fee: \$281.25	Benefit: 75% = \$210.95 85% = \$239.10
		JR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.)
42695	Fee: \$458.30	Benefit: 75% = \$343.75 85% = \$389.60
42698	LENS EXTRAC	FION, excluding surgery performed for the correction of refractive error <i>except for</i>

T8. SUR	GICAL OPERATIONS	9. OPHTHALMOLOGY
	anisometropia greater than 3 dioptres following the removal	of cataract in the first eye (Anaes.)
	(See para TN.8.80 of explanatory notes to this Category) Fee: \$604.25 Benefit: 75% = \$453.20 85% = \$519.55	
	INTRAOCULAR LENS, insertion of, excluding surgery per error <i>except for anisometropia greater than 3 dioptres follow</i> (Anaes.)	
42701	(See para TN.8.80 of explanatory notes to this Category) Fee: \$337.00 Benefit: 75% = \$252.75 85% = \$286.45	
	LENS EXTRACTION AND INSERTION OF INTRAOCUL for the correction of refractive error except for anisometropia removal of cataract in the first eye (Anaes.)	
42702	Fee: \$772.80 Benefit: 75% = \$579.60 85% = \$688.10 Extended Medicare Safety Net Cap: \$115.95	
	INTRAOCULAR LENS or IRIS PROSTHESIS insertion of, the iris or sclera (Anaes.) (Assist.)	into the posterior chamber with fixation to
42703	Fee: \$581.20 Benefit: 75% = \$435.90 85% = \$496.50	
	INTRAOCULAR LENS, REMOVAL or REPOSITIONING associated with a service to which item 42701 applies (Anae	
42704	Fee: \$473.55 Benefit: 75% = \$355.20 85% = \$402.55	
	LENS EXTRACTION AND INSERTION OF INTRAOCUL for the correction of refractive error except for anisometropia removal of cataract in the first eye, performed in association device or devices, in a patient diagnosed with open angle gla topical anti-glaucoma medications or who is intolerant of ant	a greater than 3 dioptres following the with insertion of a trans-trabecular drainage ucoma who is not adequately responsive to
42705	Fee: \$925.70 Benefit: 75% = \$694.30 85% = \$841.00 Extended Medicare Safety Net Cap: \$138.90	
	INTRAOCULAR LENS, REMOVAL of and REPLACEME performed for the correction of refractive error except for an following the removal of cataract in the first eye (Anaes.)	
42707	Fee: \$809.85 Benefit: 75% = \$607.40 85% = \$725.15	
	INTRAOCULAR LENS, removal of, and replacement with a and fixated to the iris or sclera (Anaes.) (Assist.)	a lens inserted into the posterior chamber
42710	Fee: \$916.75 Benefit: 75% = \$687.60 85% = \$832.05	
	IRIS SUTURING, McCannell technique or similar, for fixati (Anaes.) (Assist.)	ion of intraocular lens or repair of iris defect
42713	Fee: \$382.00 Benefit: 75% = \$286.50 85% = \$324.70	
	CATARACT, JUVENILE, removal of, including subsequent	t needlings (Anaes.) (Assist.)
42716	Fee: \$1,214.85 Benefit: 75% = \$911.15 85% = \$1130.15	5
	REMOVAL OF VITREOUS, and/or CAPSULAR or LENS being a service associated with a service to which item 42698 (Anaes.) (Assist.)	

T8. SUF	GICAL OPERATIONS		9. OPHTHALMOLOGY	
	Fee: \$527.30	Benefit: 75% = \$395.50 85% = \$4	148.25	
	Vitrectomy via p	pars plana sclerotomy, including one of	more of the following:	
	(a) removal of v	itreous;		
	(b) division of v	itreous bands;		
	(c) removal of e	piretinal membranes;		
	(d) capsulotomy	(Anaes.) (Assist.)		
42725	Fee: \$1,359.85	Benefit: 75% = \$1019.90		
		ARS PLANA LENSECTOMY combin 8, 42702, 42719, or 42725 (Anaes.) (A	ed with vitrectomy, not being a service associated ssist.)	
42731	Fee: \$1,543.30	Benefit: 75% = \$1157.50		
		ther than by laser, and other than a serv s (Anaes.) (Assist.)	rice associated with a service to which item 42725	
42734	Fee: \$305.55	Benefit: 75% = \$229.20 85% = \$2	259.75	
42738	 PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure. (See para TN.8.121 of explanatory notes to this Category) Fee: \$305.55 Benefit: 75% = \$229.20 85% = \$259.75 Extended Medicare Safety Net Cap: \$244.45 		treous humours for diagnostic or therapeutic	
	PARACENTES therapeutic subs	IS OF ANTERIOR CHAMBER OR V tances, or the removal of aqueous or vi	ITREOUS CAVITY, or both, for the injection of treous humours for diagnostic or therapeutic or a patient requiring anaesthetic services.	
	· •	21 of explanatory notes to this Category)		
42739	Fee: \$305.55 Extended Medi	Benefit: 75% = \$229.20 85% = \$2 icare Safety Net Cap: \$244.45	59.75	
	INTRAVITREA	AL INJECTION OF THERAPEUTIC S	SUBSTANCES, or the removal of vitreous cedure associated with other intraocular surgery.	
	(See para TN.8.121 of explanatory notes to this Category) Fee: \$305.55 Benefit: 75% = \$229.20 85% = \$259.75			
42740		icare Safety Net Cap: \$244.45		
	Posterior juxtascleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, 1 or more of (Anaes.)			
42741	(See para TN.8.81 Fee: \$305.55	of explanatory notes to this Category) Benefit: 75% = \$229.20 85% = \$2	259.75	
			FROM, as an independent procedure (Anaes.)	

T8. SUF		ONS	9. OPHTHALMOLOGY
	Needle revision of	glaucoma filtration bleb, f	ollowing glaucoma filtering procedure (Anaes.)
42744	Fee: \$305.35	Benefit: 75% = \$229.05	85% = \$259.55
	GLAUCOMA, filt contraindicated (A		conservative therapies have failed, are likely to fail, or are
42746	Fee: \$970.30	Benefit: 75% = \$727.75	
	GLAUCOMA, filt (Assist.)	ering operation for, where	previous filtering operation has been performed (Anaes.)
42749	Fee: \$1,214.85	Benefit: 75% = \$911.15	
	GLAUCOMA, ins device (Anaes.) (A	-	ncorporating an extraocular reservoir for, such as a Molteno
42752	(See para TN.8.83 of Fee: \$1,359.85	f explanatory notes to this Cat Benefit: 75% = \$1019.90	
	GLAUCOMA, ren device (Anaes.)	noval of drainage device in	corporating an extraocular reservoir for, such as a Molteno
42755	Fee: \$168.10	Benefit: 75% = \$126.10	85% = \$142.90
		treatment of primary cong ucoma drainage devices (A	enital glaucoma, excluding the minimally invasive Anaes.) (Assist.)
42758	Fee: \$710.65	Benefit: 75% = \$533.00	
	DIVISION OF AN by laser (Anaes.) (R SYNECHIAE, as an independent procedure, other than
42761	Fee: \$527.30	Benefit: 75% = \$395.50	85% = \$448.25
	IRIDECTOMY (ir other than by laser		r of iris) OR IRIDOTOMY, as an independent procedure,
42764	Fee: \$527.30	Benefit: 75% = \$395.50	85% = \$448.25
	TUMOUR, INVO (Assist.)	LVING CILIARY BODY	OR CILIARY BODY AND IRIS, excision of (Anaes.)
42767	Fee: \$1,107.80	Benefit: 75% = \$830.85	
		1	treatment of intractable glaucoma, treatment to 1 eye, to a ear period (Anaes.) (Assist.)
42770	(See para TN.8.82 of Fee: \$299.50	f explanatory notes to this Cat Benefit: 75% = \$224.65	
	DETACHED RETINA, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.)		y for, not being a service associated with a service to which
42773	Fee: \$916.75	Benefit: 75% = \$687.60	85% = \$832.05
	DETACHED RET	INA, buckling or resection	n operation for (Anaes.) (Assist.)
42776	Fee: \$1,359.85	Benefit: 75% = \$1019.90	
	DETACHED RET	INA, revision of scleral bu	ckling operation for (Anaes.) (Assist.)
42779	Fee: \$1,696.15	Benefit: 75% = \$1272.15	

GICAL OPERATIO	NS		9. OPHTHALMOLOGY
			treatment to 1 eye, to a maximum
(See para TN.8.84 of Fee: \$458.30			
	-	isode to 1 eye, to a maximum	m of 3 treatments to that eye in a 2
(See para TN.8.85 of Fee: \$359.00			
(See para TN.8.86 of Fee: \$359.00			
(See para TN.8.87 of Fee: \$359.00	• •		
		00	rgery, each treatment to 1 eye, to
(See para TN.8.88 of Fee: \$68.75			
			125), for the treatment of
Fee: \$1,066.50	Benefit: 75% = \$799.9	0	
			125), for the treatment of
Fee: \$533.10	Benefit: 75% = \$399.8	5	
Fee: \$595.90	Benefit: 75% = \$446.9	25 85% = \$511.20	
IRIS TUMOUR, la	ser photocoagulation of	(Anaes.) (Assist.)	
Fee: \$359.00	Benefit: 75% = \$269.2	25 85% = \$305.15	
PHOTOMYDRIAS	SIS, laser		
Fee: \$361.50	Benefit: 75% = \$271.1	5 85% = \$307.30	
Fee: \$361.50	Benefit: 75% = \$271.1	5 85% = \$307.30	
RETINA, photocoa	agulation of, not being a		todynamic therapy with
Fee: \$458.30		25 85% = \$389.60	
	 LASER TRABECU of 4 treatments to the (See para TN.8.84 of Fee: \$458.30 LASER IRIDOTOD year period (Anaess) (See para TN.8.85 of Fee: \$359.00 Laser capsulotomy year period—other (Assist.) (See para TN.8.86 of Fee: \$359.00 Laser vitreolysis or vitreous cavity—ea (Anaes.) (Assist.) (See para TN.8.87 of Fee: \$359.00 DIVISION OF SU a maximum of 2 tree (See para TN.8.88 of Fee: \$359.00 DIVISION OF SU a maximum of 2 tree (See para TN.8.88 of Fee: \$68.75 EPISCLERAL RA choroidal melanom Fee: \$1,066.50 EPISCLERAL RA choroidal melanom Fee: \$533.10 TANTALUM MAI planning of radioth Fee: \$595.90 IRIS TUMOUR, la Fee: \$359.00 PHOTOMYDRIAS Fee: \$361.50 RETINA, photocoa verteporfin (Anaes) 	of 4 treatments to that eye in a 2 year period(See para TN.8.84 of explanatory notes to this CFee: \$458.30Benefit: 75% = \$343.7LASER IRIDOTOMY - each treatment epryear period (Anaes.) (Assist.)(See para TN.8.85 of explanatory notes to this CFee: \$359.00Benefit: 75% = \$269.2Laser capsulotomy—each treatment episodyear period—other than a service associate(Assist.)(See para TN.8.86 of explanatory notes to this CFee: \$359.00Benefit: 75% = \$269.2Laser vitreolysis or corticolysis of lens matrixvitreous cavity—each treatment to one eye(Anaes.) (Assist.)(See para TN.8.87 of explanatory notes to this CFee: \$359.00Benefit: 75% = \$269.2DIVISION OF SUTURE BY LASER folica maximum of 2 treatments to that eye in a(See para TN.8.88 of explanatory notes to this CFee: \$68.75Benefit: 75% = \$51.60EPISCLERAL RADIOACTIVE PLAQUEchoroidal melanomas, insertion of (Anaes.)Fee: \$1,066.50Benefit: 75% = \$799.9EPISCLERAL RADIOACTIVE PLAQUEchoroidal melanomas, removal of (Anaes.)Fee: \$533.10Benefit: 75% = \$399.8TANTALUM MARKERS, surgical insertiplanning of radiotherapy of choroidal melaFee: \$359.00Benefit: 75% = \$269.2PHOTOMYDRIASIS, laserFee: \$361.50Benefit: 75% = \$271.1Laser peripheral iridoplastyFee: \$361.50Benefit: 75% = \$271.1RETINA, photocoagulation of, not being a verteporfin (Anaes.) (Assist.)	LASER TRABECULOPLASTY, for the treatment of glaucoma. Each of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para TN.8.84 of explanatory notes to this Category) Fee: \$458.30 Benefit: 75% = \$343.75 85% = \$389.60 LASER IRIDOTOMY - each treatment episode to 1 eye, to a maximum year period (Anaes.) (Assist.) (See para TN.8.85 of explanatory notes to this Category) Fee: \$359.00 Benefit: 75% = \$269.25 85% = \$305.15 Laser capsulotomy—each treatment episode to one eye, to a maximum year period —other than a service associated with a service to which it (Assist.) (See para TN.8.86 of explanatory notes to this Category) Fee: \$359.00 Benefit: 75% = \$269.25 85% = \$305.15 Laser vitreolysis or corticolysis of lens material or fibrinolysis, excludi vitreous cavity—each treatment to one eye, to a maximum of 3 treatment (Anaes.) (Assist.) (See para TN.8.87 of explanatory notes to this Category) Fee: \$359.00 Benefit: 75% = \$269.25 85% = \$305.15 DIVISION OF SUTURE BY LASER following glaucoma filtration su a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (See para TN.8.88 of explanatory notes to this Category) Fee: \$68.75 Benefit: 75% = \$51.60 85% = \$58.45 EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine choroidal melanomas, insertion of (Anaes.) (Assist.) Fee: \$1.066.50 Benefit: 75% = \$799.90 EPISCLERA

T8. SUR	GICAL OPERATI	ONS	9. OPHTHALMOLOGY
	PHOTOTHERAN for refractive error		by laser, for corneal scarring or disease, excluding surgery
42810	Fee: \$576.80	Benefit: 75% = \$432.60	85% = \$492.10
	TRANSPUPILLA malformations (A		for treatment of choroidal and retinal tumours or vascular
42811	Fee: \$458.30	Benefit: 75% = \$343.75	85% = \$389.60
	Removal of sclera (Anaes.)	al buckling material, from an	eye having undergone previous scleral buckling surgery
42812	Fee: \$168.10	Benefit: 75% = \$126.10	85% = \$142.90
			or other liquid vitreous substitutes from, during a substitute is inserted (Anaes.) (Assist.)
42815	Fee: \$641.85	Benefit: 75% = \$481.40	
	RETINA, CRYO item 42809 or 42	-	endent procedure, or when performed in conjunction with
42818	Fee: \$595.90	Benefit: 75% = \$446.95	85% = \$511.20
	OCULAR TRAN (Anaes.)	SILLUMINATION, for the o	diagnosis and measurement of intraocular tumours
42821	Fee: \$91.80	Benefit: 75% = \$68.85 8	5% = \$78.05
	RETROBULBA	R INJECTION OF ALCOHO	DL OR OTHER DRUG, as an independent procedure
42824	Fee: \$71.00	Benefit: 75% = \$53.25 8	5% = \$60.35
		ATION FOR, ON 1 OR BOT patient aged 15 years or over	HEYES, the operation involving a total of 1 OR 2 (Anaes.) (Assist.)
42833	Fee: \$595.90	Benefit: 75% = \$446.95	
	MUSCLES, on a	patient aged 14 years or unde	"H EYES, the operation involving a total of 1 OR 2 er, or where the patient has had previous squint, retinal or on a patient with concurrent thyroid eye disease (Anaes.)
42836	Fee: \$741.10	Benefit: 75% = \$555.85	
		ATION FOR, ON 1 OR BOT patient aged 15 years or over	HEYES, the operation involving a total of 3 OR MORE (Anaes.) (Assist.)
42839	Fee: \$710.65	Benefit: 75% = \$533.00	
	MUSCLES, on a	patient aged 14 years or unde	HEYES, the operation involving a total of 3 or MORE er, or where the patient has had previous squint, retinal or on a patient with concurrent thyroid eye disease (Anaes.)
42842	Fee: \$886.25	Benefit: 75% = \$664.70	
		TT OF ADJUSTABLE SUTU ration for correction of squint	JRES, 1 or both eyes, as an independent procedure (Anaes.)
42845	(See para TN.8.89	of explanatory notes to this Cate	gory)

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY
	Fee: \$192.45	Benefit: 75% = \$144.35	85% = \$163.60
	SQUINT, muscle over (Anaes.) (A	.	eim type, or similar operation) on a patient aged 15 years or
42848	Fee: \$710.65	Benefit: 75% = \$533.00	
	under, or where t	e transplant for (Hummelshe he patient has had previous ith concurrent thyroid eye d	tim type, or similar operation) on a patient aged 14 years or squint, retinal or extra ocular operations on the eye or eyes, isease (Anaes.) (Assist.)
42851	Fee: \$886.25	Benefit: 75% = \$664.70	
	RUPTURED MI (Anaes.) (Assist.		MENT or ruptured EXTRAOCULAR MUSCLE, repair of
42854	Fee: \$412.55	Benefit: 75% = \$309.45	85% = \$350.70
		OF WOUND FOLLOWING psed iris (Anaes.) (Assist.)	G INTRAOCULAR PROCEDURES with or without
42857	Fee: \$412.55	Benefit: 75% = \$309.45	85% = \$350.70
	EYELID (upper retractors (Anaes		a or other non-autogenous graft to, with recession of the lid
42860	Fee: \$916.75	Benefit: 75% = \$687.60	85% = \$832.05
	EYELID, recessi	on of (Anaes.) (Assist.)	
42863	Fee: \$786.95	Benefit: 75% = \$590.25	85% = \$702.25
			epair of, by tightening, shortening or repair of inferior width of the eyelid (Anaes.) (Assist.)
42866	Fee: \$763.90	Benefit: 75% = \$572.95	85% = \$679.20
	EYELID closure	in facial nerve paralysis, in	sertion of foreign implant for (Anaes.) (Assist.)
42869	Fee: \$557.80	Benefit: 75% = \$418.35	85% = \$474.15
			to correct for a reduced field of vision caused by paretic, tosis to a position below the superior orbital rim (Anaes.)
42872	Fee: \$244.55	Benefit: 75% = \$183.45	85% = \$207.90
		-thermal laser at a waveleng	e infusion of Verteporfin continuously through a peripheral gth of 689nm, for the treatment of choroidal
43021	Fee: \$462.35	Benefit: 75% = \$346.80	85% = \$393.00
		using a non-thermal laser at	the infusion of Verteporfin continuously through a a wavelength of 689nm, for the treatment of choroidal
43022	Fee: \$554.90	Benefit: 75% = \$416.20	85% = \$471.70
			todynamic therapy, where a session of therapy which would 122 has been discontinued on medical grounds.
43023	Fee: \$89.90	Benefit: 75% = \$67.45	85% = \$76.45

Group T8. Surgical Operations
Subgroup 10. Operations For Osteomyelitis
ACUTE
OPERATION ON PHALANX (Anaes.)
Fee: \$125.30 Benefit: 75% = \$94.00
OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.)
Fee: \$208.00 Benefit: 75% = \$156.00
OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.)
Fee: \$362.05 Benefit: 75% = \$271.55
OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.)
Fee: \$362.05 Benefit: 75% = \$271.55
CHRONIC
OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.) (Assist.)
Fee: \$362.05 Benefit: 75% = \$271.55
OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.)
Fee: \$362.05 Benefit: 75% = \$271.55 85% = \$307.75
OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.)
Fee: \$597.00 Benefit: 75% = \$447.75
OPERATION ON SKULL (Anaes.) (Assist.)
Fee: \$471.95 Benefit: 75% = \$354.00
OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.)
Fee: \$597.00 Benefit: 75% = \$447.75 85% = \$512.30
GICAL OPERATIONS 11. PAEDIATRIC
Group T8. Surgical Operations
Subgroup 11. Paediatric
SURGERY IN NEONATE OR YOUNG CHILD
INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.)
Fee: \$972.60 Benefit: 75% = \$729.45

T8. SUF	RGICAL OPERATIO	NS	11. PAEDIATRIC
		LROTATION with or without volvulus, laparotomy or without formation of stoma (Anaes.) (Assist.)	for, with bowel resection and
43804	Fee: \$1,035.55	Benefit: 75% = \$776.70	
	UMBILICAL, EPI (Anaes.)	GASTRIC OR LINEA ALBA HERNIA, repair of, or	n a person under 10 years of age
43805	Fee: \$362.05	Benefit: 75% = \$271.55	
	DUODENAL ATR (Assist.)	ESIA or STENOSIS, duodenoduodenostomy or duo	denojejunostomy for (Anaes.)
43807	Fee: \$1,129.80	Benefit: 75% = \$847.35	
	JEJUNAL ATRES	IA, bowel resection and anastomosis for, with or with	hout tapering (Anaes.) (Assist.)
43810	Fee: \$1,318.10	Benefit: 75% = \$988.60	
		JS, laparotomy for, complicated by 1 or more of asso without meconium peritonitis (Anaes.) (Assist.)	ociated volvulus, atresia, intesinal
43813	Fee: \$1,318.10	Benefit: 75% = \$988.60	
		COLONIC ATRESIA OR MECONIUM ILEUS not tem 43813 applies, laparotomy for (Anaes.) (Assist.)	
43816	Fee: \$1,223.85	Benefit: 75% = \$917.90	
	Agangliosis Coli, la (Anaes.) (Assist.)	aparotomy for, with or without frozen section biopsic	es and formation of stoma
43819	Fee: \$988.50	Benefit: 75% = \$741.40	
	ANORECTAL MA	LFORMATION, laparotomy and colostomy for (An	naes.) (Assist.)
43822	Fee: \$988.50	Benefit: 75% = \$741.40	
		MENTARY OBSTRUCTION, laparotomy for, not be up applies (Anaes.) (Assist.)	eing a service to which any other
43825	Fee: \$1,129.80	Benefit: 75% = \$847.35	
		AL NECROTISING ENTEROCOLITIS, laparotomy stoma formation (Anaes.) (Assist.)	y for, with resection, including
43828	Fee: \$1,248.20	Benefit: 75% = \$936.15	
	ACUTE NEONAT laparotomy for (An	AL NECROTISING ENTEROCOLITIS where no de taes.) (Assist.)	efinitive procedure is possible,
43831	Fee: \$972.60	Benefit: 75% = \$729.45	
	BRANCHIAL FIS	TULA, on a person under 10 years of age. Removal	of, (Anaes.) (Assist.)
43832	Fee: \$663.40	Benefit: 75% = \$497.55	
	BOWEL RESECT stoma formation (A	ION for necrotising enterocolitis stricture or stricture anaes.) (Assist.)	s, including any anastomoses or
43834	Fee: \$1,129.80	Benefit: 75% = \$847.35	
43835		D, INCARCERATED OR OBSTRUCTED HERNIA	, repair of, without bowel

T8. SUF	GICAL OPERATIO	DNS	11. PAEDIATRIC
	resection, on a per	son under 10 years of age (Anaes.) (Assist.)	
	Fee: \$688.50	Benefit: 75% = \$516.40	
		IAPHRAGMATIC HERNIA, repair by thoracic or ed in the first 24 hours of life (Anaes.) (Assist.)	abdominal approach, with
43837	Fee: \$1,412.15	Benefit: 75% = \$1059.15	
	1 0	nia, congential repair of, by thoracic or abdominal s 31569 to 31581 apply, on a person under 10 years	
43838	Fee: \$1,264.40	Benefit: 75% = \$948.30	
		IAPHRAGMATIC HERNIA, repair by thoracic or of life and before 20 days of age (Anaes.) (Assist.)	abdominal approach, diagnosed
43840	Fee: \$1,223.85	Benefit: 75% = \$917.90	
		NGUINAL HERNIA OR INFANTILE HYDROCE or 43835 applies, on a person under 10 years of ag	
43841	Fee: \$613.50	Benefit: 75% = \$460.15	
		ATRESIA (with or without repair of tracheo-oesopeing a service to which item 43846 applies (Anaes	
43843	Fee: \$1,883.00	Benefit: 75% = \$1412.25	
		ATRESIA (with or without repair of tracheo-oesop fant of birth weight less than 1500 grams (Anaes.)	
43846	Fee: \$2,024.20	Benefit: 75% = \$1518.15	
	OESOPHAGEAL	ATRESIA, gastrostomy for (Anaes.) (Assist.)	
43849	Fee: \$517.80	Benefit: 75% = \$388.35	
	OESOPHAGEAL anastomosis (Anae	ATRESIA, thoracotomy for, and division of trache es.) (Assist.)	eo-oesophageal fistula without
43852	Fee: \$1,647.50	Benefit: 75% = \$1235.65	
	OESOPHAGEAL	ATRESIA, delayed primary anastomosis for (Anae	es.) (Assist.)
43855	Fee: \$1,741.80	Benefit: 75% = \$1306.35	
	OESOPHAGEAL	ATRESIA, cervical oesophagostomy for (Anaes.)	(Assist.)
43858	Fee: \$611.90	Benefit: 75% = \$458.95	
		YSTADENOMATOID MALFORMATION OR C to a contract of the section of t	
43861	Fee: \$1,694.75	Benefit: 75% = \$1271.10	
	GASTROSCHISIS	S, operation for (Anaes.) (Assist.)	
43864	Fee: \$1,271.05	Benefit: 75% = \$953.30	
	GASTROSCHISIS	S or Exomphalos, secondary operation for, with ren	noval of silo (Anaes.) (Assist.)
43867	Fee: \$706.10	Benefit: 75% = \$529.60	

T8. SUF	GICAL OPERATI	ONS 11. PAEDIA	TRIC	
	EXOMPHALOS	containing small bowel only, operation for (Anaes.) (Assist.)		
43870	Fee: \$988.50	Benefit: 75% = \$741.40		
	EXOMPHALOS	containing small bowel and other viscera, operation for (Anaes.) (Assist.)		
43873	Fee: \$1,318.10	Benefit: 75% = \$988.60		
	SACROCOCCY	GEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.)		
43876	Fee: \$1,129.80	Benefit: 75% = \$847.35		
	SACROCOCCY((Anaes.) (Assist.)	GEAL TERATOMA, excision of, by combined posterior and abdominal approach	1	
43879	Fee: \$1,318.10	Benefit: 75% = \$988.60		
	CLOACAL EXS	TROPHY, operation for (Anaes.) (Assist.)		
43882	Fee: \$1,694.75	Benefit: 75% = \$1271.10 85% = \$1610.05		
		THORACIC SURGERY		
	TRACHEO-OES	OPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.)		
43900	Fee: \$1,129.80	Benefit: 75% = \$847.35		
		ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal atilizing gastric tube, jejunum or colon (Anaes.) (Assist.)		
43903	Fee: \$1,883.00	Benefit: 75% = \$1412.25		
		resection of congenital, anastomic or corrosive stricture and anastomosis, not bein tem 43903 applies (Anaes.) (Assist.)	ng a	
43906	Fee: \$1,647.50	Benefit: 75% = \$1235.65		
	TRACHEOMAL	ACIA, aortopexy for (Anaes.) (Assist.)		
43909	Fee: \$1,647.50	Benefit: 75% = \$1235.65		
	THORACOTOM teratoma (Anaes.)	Y and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal (Assist.)		
43912	Fee: \$1,556.50	Benefit: 75% = \$1167.40		
	EVENTRATION	, plication of diaphragm for (Anaes.) (Assist.)		
43915	Fee: \$1,176.85	Benefit: 75% = \$882.65		
	ABDOMINAL SURGERY			
	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.)			
43930	Fee: \$452.55	Benefit: 75% = \$339.45		
		TUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.)		
43933	Fee: \$529.75	Benefit: 75% = \$397.35		
		TION, laparotomy and resection with anastomosis (Anaes.) (Assist.)		
43936	Fee: \$988.50	Benefit: 75% = \$741.40		
43939		NIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.))	

T8. SUF		IONS 11. PAEDIATRIC
	(Assist.)	
	Fee: \$753.15	Benefit: 75% = \$564.90
	ABDOMINAL W	VALL VITELLO INTESTINAL REMNANT, excision of (Anaes.)
43942	Fee: \$235.40	Benefit: 75% = \$176.55
	PATENT VITEL	LO INTESTINAL DUCT, excision of (Anaes.) (Assist.)
43945	Fee: \$988.50	Benefit: 75% = \$741.40
	UMBILICAL GI	RANULOMA, excision of, under general anaesthesia (Anaes.)
43948	Fee: \$141.35	Benefit: 75% = \$106.05
		PHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, omy (Anaes.) (Assist.)
43951	Fee: \$885.25	Benefit: 75% = \$663.95
		PHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, y (Anaes.) (Assist.)
43954	Fee: \$1,082.80	Benefit: 75% = \$812.10
		PHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or rnia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.)
43957	Fee: \$1,176.85	Benefit: 75% = \$882.65
	ANORECTAL M	ALFORMATION, perineal anoplasty of (Anaes.) (Assist.)
43960	Fee: \$414.00	Benefit: 75% = \$310.50
	ANORECTAL M	ALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.)
43963	Fee: \$1,647.50	Benefit: 75% = \$1235.65
	ANORECTAL N (Assist.)	ALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.)
43966	Fee: \$1,883.00	Benefit: 75% = \$1412.25
		LOACA, total correction of, with genital repair using posterior sagittal approach, with
	or without laparo	tomy (Anaes.) (Assist.)
43969	Fee: \$2,589.10	Benefit: 75% = \$1941.85
	CHOLEDOCHA	L CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.)
43972	Fee: \$1,883.00	Benefit: 75% = \$1412.25
	CHOLEDOCHA	L CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.)
43975	Fee: \$2,212.55	Benefit: 75% = \$1659.45
	BILIARY ATRE	SIA, portoenterostomy for (Anaes.) (Assist.)
43978	Fee: \$1,883.00	Benefit: 75% = \$1412.25
43981		FOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy cluding associated biopsies, where no other intra-abdominal procedure is performed

T8. SUF	GICAL OPERATIO	DNS 11. PAEDIATRIC
	(Anaes.) (Assist.)	
	Fee: \$517.80	Benefit: 75% = \$388.35
	NEPHROBLAST	OMA, radical nephrectomy for (Anaes.) (Assist.)
43984	Fee: \$1,318.10	Benefit: 75% = \$988.60
	NEUROBLASTO	MA, radical excision of (Anaes.) (Assist.)
43987	Fee: \$1,459.40	Benefit: 75% = \$1094.55
		i, definitive resection with pull-through anastomosis, with or without frozen section anglionic segment extends to sigmoid colon (Anaes.) (Assist.)
43990	Fee: \$1,788.90	Benefit: 75% = \$1341.70
		i, definitive resection with pull-through anastomosis, with or without frozen section anglionic segment extends into descending or transverse colon with or without resiting (Assist.)
43993	Fee: \$1,930.05	Benefit: 75% = \$1447.55
		i, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or e ileocolic anastomosis (Anaes.) (Assist.)
43996	Fee: \$2,165.45	Benefit: 75% = \$1624.10
	Aganglionosis Col	i, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.)
43999	Fee: \$270.80	Benefit: 75% = \$203.10
		nation of, on a person under 2 years of age, under general anaesthesia with full r removal of polyp or similar lesion (Anaes.) (Assist.)
44101	Fee: \$339.40	Benefit: 75% = \$254.55
		nation of, on a person 2 years of age or over, under general anaesthesia with full r removal of polyp or similar lesion (Anaes.) (Assist.)
44102	Fee: \$261.05	Benefit: 75% = \$195.80
	RECTAL PROLA under general anae	PSE, SUBMUCOSAL or perirectal injection for, on a person under 2 years of age, esthesia (Anaes.)
44104	Fee: \$59.60	Benefit: 75% = \$44.70 85% = \$50.70
	RECTAL PROLA under general anac	PSE, SUBMUCOSAL or perirectal injection for, on a person 2 years of age or over, esthesia (Anaes.)
44105	Fee: \$45.80	Benefit: 75% = \$34.35 85% = \$38.95
	INGUINAL HERI	NIA repair at age less than 12 months (Anaes.) (Assist.)
44108	Fee: \$499.30	Benefit: 75% = \$374.50
		PR STRANGULATED INGUINAL HERNIA, repair, at age, less than 12 months bexy when performed (Anaes.) (Assist.)
44111	Fee: \$584.85	Benefit: 75% = \$438.65 85% = \$500.15
44114	INGUINAL HERI (Assist.)	NIA repair at age less than 12 months when orchidopexy also required (Anaes.)
44114		

T8. SUF	RGICAL OPERAT	ONS	11. PAEDIATRIC
	Fee: \$584.85	Benefit: 75% = \$438.65	
		MISCELLANEOUS SUR	GERY
	LYMPHADENE (Assist.)	CTOMY, for atypical mycobacterial infection	on or other granulomatous disease (Anaes.)
44130	Fee: \$470.70	Benefit: 75% = \$353.05 85% = \$400.10	
	TORTICOLLIS,	open division of sternomastoid muscle for (A	Anaes.) (Assist.)
44133	Fee: \$373.65	Benefit: 75% = \$280.25	
	INGROWN TOP	NAIL, operation for, under general anaesth	esia (Anaes.)
44136	Fee: \$172.20	Benefit: 75% = \$129.15 85% = \$146.40	
T8. SUF	RGICAL OPERAT	ONS	12. AMPUTATIONS
	Group T8. Surgi	cal Operations	
		Subgroup 12. Amput	ations
	HAND, MIDCA	RPAL OR TRANSMETACARPAL, amputa	tion of (Anaes.) (Assist.)
44325	Fee: \$300.45	Benefit: 75% = \$225.35 85% = \$255.40	
	HAND, FOREA	RM OR THROUGH ARM, amputation of (A	Anaes.) (Assist.)
44328	Fee: \$362.05	Benefit: 75% = \$271.55	
		AT SHOULDER (Anaes.) (Assist.)	
44331	Fee: \$597.00	Benefit: 75% = \$447.75	
	INTERSCAPUL	OTHORACIC AMPUTATION (Anaes.) (As	ssist.)
44334	Fee: \$1,213.35	Benefit: 75% = \$910.05 85% = \$1128.65	
	1 DIGIT of foot,	amputation of (Anaes.)	
44338	Fee: \$146.30	Benefit: 75% = \$109.75 85% = \$124.40	
	2 DIGITS of 1 fo	ot, amputation of (Anaes.)	
44342	Fee: \$223.45	Benefit: 75% = \$167.60	
	3 DIGITS of 1 fo	ot, amputation of (Anaes.) (Assist.)	
44346	Fee: \$258.05	Benefit: 75% = \$193.55	
	4 DIGITS of 1 fo	ot, amputation of (Anaes.) (Assist.)	
44350	Fee: \$292.80	Benefit: 75% = \$219.60 85% = \$248.90	
		ot, amputation of (Anaes.) (Assist.)	
44354	Fee: \$335.10	Benefit: 75% = \$251.35	
		hetatarsal or part of metatarsal each toe, am	putation of (Anaes.)
44358	Fee: \$186.85	Benefit: 75% = \$140.15	
		TOES OF ONE FOOT, amputation of, inclu	uding if performed, excision of 1 or more
44359		of the foot, performed for diabetic or other r	

T8. SUF	RGICAL OPERAT	IONS	12. AMPUTATIONS
	(Anaes.) (Assist.)	
	Fee: \$268.15	Benefit: 75% = \$201.15	
	FOOT AT ANK	LE (Syme, Pirogoff types), amputation of (Anae	s.) (Assist.)
44361	Fee: \$362.05	Benefit: 75% = \$271.55	
	FOOT, MIDTAF	RSAL OR TRANSMETATARSAL, amputation	of (Anaes.) (Assist.)
44364	Fee: \$300.45	Benefit: 75% = \$225.35	
	AMPUTATION	THROUGH THIGH, AT KNEE OR BELOW K	KNEE (Anaes.) (Assist.)
44367	Fee: \$530.30	Benefit: 75% = \$397.75	
	AMPUTATION	AT HIP (Anaes.) (Assist.)	
44370	Fee: \$731.70	Benefit: 75% = \$548.80	
		R, amputation of (Anaes.) (Assist.)	
44373	Fee: \$1,502.05	Benefit: 75% = \$1126.55 85% = \$1417.35	
11373		STUMP, reamputation of, to provide adequate s	kin and muscle cover (Assist.)
44376	Derived Feet 75	% of the original amputation fee	
	RGICAL OPERAT		ND RECONSTRUCTIVE SURGERY
10. 301		IONS IS. FLASTIC A	ND RECONSTRUCTIVE SURGERT
	Group T8. Surgi	cal Operations	
		Subgroup 13. Plastic And Reconstru	uctive Surgery
		GENERAL	
		l muscle flap repair, on eyelid, nose, lip, neck, h any of items 31356 to 31376 (Anaes.)	and, thumb, finger or genitals not in
45000	Fee: \$550.00	Benefit: 75% = \$412.50 85% = \$467.50	
		l myocutaneous flap repair to one defect, simple o 31376 (Anaes.)	and small not in association with any
45003	Fee: \$611.30 Extended Medie	Benefit: 75% = \$458.50 85% = \$526.60 care Safety Net Cap: \$489.05	
		E LARGE MYOCUTANEOUS FLAP REPAIR arge muscle) (Anaes.) (Assist.)	to 1 defect, (pectoralis major, latissimus
45006	Fee: \$1,054.25	Benefit: 75% = \$790.70	
	SINGLE STAGE	E LOCAL muscle flap repair to 1 defect, simple	and small (Anaes.) (Assist.)
45009	Fee: \$385.10	Benefit: 75% = \$288.85	
		E LARGE MUSCLE FLAP REPAIR to 1 defect, r large muscle) (Anaes.) (Assist.)	, (pectoralis major, gastrocnemius,
45012	Fee: \$645.15	Benefit: 75% = \$483.90	
		YOCUTANEOUS FLAP, delay of (Anaes.)	
45015			

T8. SUF	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGER'			
	Fee: \$305.55 Benefit: 75% = \$229.20			
	Dermis, dermofat or fascia graft (excluding transfer of fat by injection), if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items 51011 to 51171 (Anaes.) (Assist.)			
45018	Fee: \$481.25 Benefit: 75% = \$360.95 85% = \$409.10			
	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			
	(d) at least medium depth peeling agents are used; and			
	(e) the chemical peel is performed in the operating theatre of a hospital by a medical practitioner recognised as a specialist in the specialty of dermatology or plastic surgery.			
	Applicable once only in any 12 month period (Anaes.)			
45019	Fee: \$403.05 Benefit: 75% = \$302.30			
	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.)			
45021	(See para TN.8.91 of explanatory notes to this Category)Fee: $\$180.20$ Benefit: $75\% = \$135.15$ $85\% = \$153.20$			
	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.)			
45024	(See para TN.8.91 of explanatory notes to this Category) Fee: \$404.95 Benefit: 75% = \$303.75 85% = \$344.25			
	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.)			
	(See para TN.8.91 of explanatory notes to this Category)Fee: $\$180.20$ Benefit: $75\% = \$135.15$ $85\% = \$153.20$			
45025	Extended Medicare Safety Net Cap: \$144.20			
	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.)			
	(See para TN.8.91 of explanatory notes to this Category) Fee: \$404.95 Benefit: 75% = \$303.75 85% = \$344.25			
45026	Extended Medicare Safety Net Cap: \$324.00			

T8. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY
	ANGIOMA, cauterisation (Anaes.)	of or injection into, where undertaken in the operating theatre of a hospital
45027	Fee: \$122.30 Benef	it: $75\% = \$91.75$ $85\% = \$104.00$
		or lymphangioma or both) of skin and subcutaneous tissue (excluding facial s surface, small, excision and suture of (Anaes.)
45030	Fee: \$131.30 Benef	it: $75\% = \$98.50$ $85\% = \$111.65$
	ANGIOMA, (haemangiom muscle or breast, excision a	a or lymphangioma or both), large or involving deeper tissue including facial nd suture of (Anaes.)
45033	Fee: \$244.55 Benef	it: 75% = \$183.45 85% = \$207.90
	ANGIOMA (haemangioma excision of (Anaes.) (Assis	or lymphangioma or both), large and deep, involving muscles or nerves,
45035	Fee: \$713.30 Benef	it: 75% = \$535.00
	ANGIOMA (haemangioma	or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.)
45036	Fee: \$1,146.10 Benef	it: 75% = \$859.60
	ARTERIOVENOUS MAL (Anaes.)	FORMATION (3 centimetres or less) of superficial tissue, excision of
45039	Fee: \$244.55 Benef	it: 75% = \$183.45 85% = \$207.90
	ARTERIOVENOUS MAL	FORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.)
45042	Fee: \$313.35 Benef	it: 75% = \$235.05 85% = \$266.35
	ARTERIOVENOUS MAL excision of (Anaes.)	FORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals,
45045	Fee: \$313.35 Benef	it: 75% = \$235.05 85% = \$266.35
	LYMPHOEDEMATOUS t forearm and hand, major ex	issue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or cision of (Anaes.) (Assist.)
45048	Fee: \$786.95 Benef	it: 75% = \$590.25
	Contour reconstruction by	open repair of contour defects, due to deformity, if:
		urgery is indicated because the deformity is secondary to congenital absence trauma (other than trauma from previous cosmetic surgery); and
	(b) insertion of a non-biolo	gical implant is required, other than one or more of the following:
	(i) insertion of a non- T8;	biological implant that is a component of another service specified in Group
	(ii) injection of liquid	or semisolid material;
	(iii) an oral and maxil	lofacial implant service to which item 52321 applies;
	(iv) a service to insert	mesh; and
	(c) photographic and/or dia documented in the patient r	gnostic imaging evidence demonstrating the clinical need for this service is totes (Anaes.) (Assist.)
45051	r	

T8. SUF	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY			
	Fee: \$481.35 Benefit: 75% = \$361.05			
	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.)			
45054	(See para TN.8.92 of explanatory notes to this Category) Fee: \$250.05 Benefit: 75% = \$187.55			
	Developmental breast abnormality, single stage correction of, if:			
	(a) the correction involves either:			
	(i) bilateral mastopexy for symmetrical tubular breasts; or			
	(ii) surgery on both breasts with a combination of insertion of one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least 20% in normally shaped breasts, or 10% in tubular breasts or in breasts with abnormally high inframammary folds; and			
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes			
	Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)			
45060	Fee: \$1,291.65 Benefit: 75% = \$968.75			
	Developmental breast abnormality, 2 stage correction of, first stage, involving surgery on both breasts with a combination of insertion of one or more tissue expanders, mastopexy or reduction mammaplasty, if:			
	(a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least:			
	(i) 20% in normally shaped breasts; or			
	(ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and			
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes.			
	Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)			
45061	Fee: \$1,291.65 Benefit: 75% = \$968.75			
	Developmental breast abnormality, 2 stage correction of, second stage, involving surgery on both breasts with a combination of exchange of one or more tissue expanders for one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if:			
	(a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least:			
	(i) 20% in normally shaped breasts; or			
	(ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and			
450.52	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes.			
45062				

T8. SUR	URGICAL OPERATIONS 13. PLASTIC	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Applicable only once per occasion on which the service is pr	ovided (Anaes.) (Assist.)	
	Fee: \$934.70 Benefit: 75% = \$701.05		
	SKIN FLAP SURGE	RY	
	Single stage local flap, if indicated to repair one defect, simp baldness and excluding H-flap or double advancement flap n 31376 (Anaes.)		
45200	(See para TN.8.93 of explanatory notes to this Category) Fee: \$288.90 Benefit: 75% = \$216.70 85% = \$245.60 Extended Medicare Safety Net Cap: \$231.15		
+3200		1 / · · · · · · · · · · · · · · · · · ·	
	Muscle, myocutaneous or skin flap, where clinically indicate removal of a malignant or non-malignant skin lesion (only in 31002, 31003, 31004, 31005, 31358, 31359, 31360, 31363, 3	association with items 31000, 31001,	
	31376)-may be claimed only once per defect (Anaes.)		
45201	(See para TN.8.93 of explanatory notes to this Category) Fee: \$420.55 Benefit: 75% = \$315.45 85% = \$357.50		
	Muscle, myocutaneous or skin flap, where clinically indicate removal of a malignant or non-malignant skin lesion in a pati procedure is clearly annotated in the patient's record and eith	ient, if the clinical relevance of the	
	(a) item 45201 applies and additional flap repair is require	d for the same defect; or	
	(b) item 45201 does not apply and either:		
	(i) the patient has severe pre-existing scarring, severe sk	in atrophy or sclerodermoid changes; or	
	(ii) the repair is contiguous with a free margin (Anaes.)		
45202	(See para TN.8.93, TN.8.126 of explanatory notes to this Category) Fee: \$420.55 Benefit: 75% = \$315.45 85% = \$357.50		
	Single stage local flap, if indicated to repair one defect, comp pattern baldness and excluding H-flap or double advancemer 31356 to 31376 (Anaes.) (Assist.)		
	(See para TN.8.93 of explanatory notes to this Category)		
45203	Fee: \$412.55 Benefit: 75% = \$309.45 85% = \$350.70 Extended Medicare Safety Net Cap: \$330.05		
	Single stage local flap if indicated to repair one defect, on ey finger or genitals and excluding H-flap or double advanceme 31356 to 31376 (Anaes.)		
45206	(See para TN.8.93 of explanatory notes to this Category) Fee: \$389.70 Benefit: 75% = \$292.30 85% = \$331.25 Extended Medicare Safety Net Cap: \$311.80		
	H-flap or double advancement flap if indicated to repair one in association with any of items 31356 to 31376 (Anaes.)	defect, on eyelid, eyebrow or forehead not	
45207	Fee: \$389.70 Benefit: 75% = \$292.30 85% = \$331.25		
	DIRECT FLAP REPAIR (cross arm, abdominal or similar),	first stage (Anaes.) (Assist.)	
45209	Fee: \$481.35 Benefit: 75% = \$361.05 85% = \$409.15		

T8. SUR	GICAL OPERAT	IONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	DIRECT FLAP	REPAIR (cross arm, abdominal or similar), second stage (Anaes.)	
45212	Fee: \$238.80	Benefit: 75% = \$179.10 85% = \$203.00	
	DIRECT FLAP	REPAIR, cross leg, first stage (Anaes.) (Assist.)	
45215	Fee: \$1,030.25	Benefit: 75% = \$772.70	
	DIRECT FLAP	REPAIR, cross leg, second stage (Anaes.) (Assist.)	
45218	Fee: \$462.15	Benefit: 75% = \$346.65	
	DIRECT FLAP	REPAIR, small (cross finger or similar), first stage (Anaes.)	
45221	Fee: \$265.75	Benefit: 75% = \$199.35 85% = \$225.90	
	DIRECT FLAP	REPAIR, small (cross finger or similar), second stage (Anaes.)	
45224	Fee: \$119.45	Benefit: 75% = \$89.60 85% = \$101.55	
	INDIRECT FLA	AP OR TUBED PEDICLE, formation of (Anaes.) (Assist.)	
45227	Fee: \$452.55	Benefit: 75% = \$339.45 85% = \$384.70	
	DIRECT OR IN	DIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.)	
45230	Fee: \$226.30	Benefit: 75% = \$169.75 85% = \$192.40	
	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the		
	site (Anaes.) (As	ssist.)	
45233	Fee: \$481.35	Benefit: 75% = \$361.05 85% = \$409.15	
	INDIRECT FLA	AP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.)	
45236	Fee: \$377.45	Benefit: 75% = \$283.10	
		RECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to 10 applies (Anaes.)	
45239	Fee: \$265.75	Benefit: 75% = \$199.35 85% = \$225.90	
		RECT OR LOCAL FLAP, revision of, by liposuction, not being a service to which item 5498 or 45499 applies (Anaes.)	
45240	Fee: \$265.75	Benefit: 75% = \$199.35 85% = \$225.90	
		FREE GRAFTS	
	FREE GRAFTI	NG (split skin) of a granulating area, small (Anaes.)	
45400	Fee: \$208.00	Benefit: 75% = \$156.00 85% = \$176.80	
	FREE GRAFTI	NG (split skin) of a granulating area, extensive (Anaes.) (Assist.)	
45403	Fee: \$414.00	Benefit: 75% = \$310.50 85% = \$351.90	
		NG (split skin) to burns, including excision of burnt tissue - involving not more than 3 body surface (Anaes.) (Assist.)	
		of explanatory notes to this Category)	
45406	Fee: \$458.30	Benefit: 75% = \$343.75 85% = \$389.60	
45409	FREE GRAFTI	NG (split skin) to burns, including excision of burnt tissue - involving 3 per cent or more	

T8. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY
	but less than 6 per cent	of total body surface (Anaes.) (Assist.)
		lanatory notes to this Category) enefit: 75% = \$458.50
		lit skin) to burns, including excision of burnt tissue - involving 6 per cent or more of total body surface (Anaes.) (Assist.)
45412		lanatory notes to this Category) enefit: 75% = \$630.45
		lit skin) to burns, including excision of burnt tissue - involving 9 per cent or more at of total body surface (Anaes.) (Assist.)
45415		anatory notes to this Category) enefit: 75% = \$687.60
		lit skin) to burns, including excision of burnt tissue - involving 12 per cent or er cent of total body surface (Anaes.) (Assist.)
45418	Fee: \$993.20 B	lanatory notes to this Category) enefit: 75% = \$744.90
	FREE GRAFTING (sp	lit skin) to 1 defect, including elective dissection, small (Anaes.)
45439	Fee: \$288.90 B	enefit: 75% = \$216.70 85% = \$245.60
	FREE GRAFTING (sp	lit skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.)
45442	Fee: \$595.90 B	enefit: 75% = \$446.95 85% = \$511.20
		lit skin) as inlay graft to 1 defect including elective dissection using a mould and removal of mould) (Anaes.) (Assist.)
45445	Fee: \$565.50 B	enefit: 75% = \$424.15 85% = \$480.80
		lit skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, genitals, not being a service to which item 45442 or 45445 applies (Anaes.)
45448	Fee: \$382.00 B	enefit: 75% = \$286.50 85% = \$324.70
	FREE GRAFTING (fu (Assist.)	ll thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.)
45451	Fee: \$481.35 B	enefit: 75% = \$361.05 85% = \$409.15
		lit skin) to burns, including excision of burnt tissue - involving 15 percent or bercent of total body surface - one surgeon (Anaes.) (Assist.)
45460	Fee: \$1,273.35 B	enefit: 75% = \$955.05
		lit skin) to burns, including excision of burnt tissue - involving 15 percent or bercent of total body surface - conjoint surgery, principal surgeon (Anaes.)
45461	Fee: \$907.55 B	enefit: 75% = \$680.70
		lit skin) to burns, including excision of burnt tissue - involving 15 percent or bercent of total body surface - conjoint surgery, co- surgeon (Assist.)
45462	Fee: \$684.85 B	enefit: 75% = \$513.65
45464	FREE GRAFTING (sp	lit skin) to burns, including excision of burnt tissue - involving 20 percent or

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	more but less than 30 percent of total l	body surface - one surgeon (Anaes.) (Assist.)
	Fee: \$1,943.70 Benefit: 75% = \$2	457.80
		s, including excision of burnt tissue - involving 20 percent or body surface - conjoint surgery, principal surgeon (Anaes.)
45465	Fee: \$1,384.80 Benefit: 75% = \$	1038.60 85% = \$1300.10
		s, including excision of burnt tissue - involving 20 percent or body surface - conjoint surgery, co-surgeon (Assist.)
45466	Fee: \$1,044.40 Benefit: 75% = \$7	783.30 85% = \$959.70
		s, including excision of burnt tissue - involving 30 percent or body surface - conjoint surgery, principal surgeon (Anaes.)
45468	Fee: \$1,861.95 Benefit: 75% = \$	1396.50
		s, including excision of burnt tissue - involving 30 percent or body surface - conjoint surgery, co-surgeon (Assist.)
45469	Fee: \$1,404.80 Benefit: 75% = \$	1053.60 85% = \$1320.10
		s, including excision of burnt tissue - involving 40 percent or body surface - conjoint surgery, principal surgeon (Anaes.)
45471	Fee: \$2,340.50 Benefit: 75% = \$1	1755.40 85% = \$2255.80
		s, including excision of burnt tissue - involving 40 percent or body surface - conjoint surgery, co-surgeon (Assist.)
45472	Fee: \$1,765.40 Benefit: 75% = \$	324.05 85% = \$1680.70
		s, including excision of burnt tissue - involving 50 percent or body surface - conjoint surgery, principal surgeon (Anaes.)
45474	Fee: \$2,817.65 Benefit: 75% = \$2	2113.25 85% = \$2732.95
		s, including excision of burnt tissue - involving 50 percent or body surface - conjoint surgery, co-surgeon (Assist.)
45475	Fee: \$2,125.95 Benefit: 75% = \$	1594.50 85% = \$2041.25
		s, including excision of burnt tissue - involving 60 percent or body surface - conjoint surgery, principal surgeon (Anaes.)
45477	Fee: \$3,294.90 Benefit: 75% = \$2	2471.20 85% = \$3210.20
	FREE GRAFTING (split skin) to burn	s, including excision of burnt tissue - involving 60 percent or body surface - conjoint surgery, co-surgeon (Assist.)
45478	Fee: \$2,485.20 Benefit: 75% = \$3	863.90 85% = \$2400.50
45480	FREE GRAFTING (split skin) to burn	s, including excision of burnt tissue - involving 70 percent or body surface - conjoint surgery, principal surgeon (Anaes.)

T8. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
(Assist.)			
Fee: \$3,772.00	Benefit: 75% = \$2829.00	85% = \$3687.30	
		ing excision of burnt tissue - involving 70 percent or cace - conjoint surgery, co-surgeon (Assist.)	
Fee: \$2,845.90	Benefit: 75% = \$2134.45	85% = \$2761.20	
		ing excision of burnt tissue - involving 80 percent or rincipal surgeon (Anaes.) (Assist.)	
Fee: \$4,297.65	Benefit: 75% = \$3223.25	85% = \$4212.95	
		ing excision of burnt tissue - involving 80 percent or o-surgeon (Assist.)	
Fee: \$3,242.55	Benefit: 75% = \$2431.95	85% = \$3157.85	
		ng excision of burnt tissue - upper eyelid, nose, lip, ear	
Fee: \$536.15	Benefit: 75% = \$402.15		
	· •	ng excision of burnt tissue - forehead, cheek, anterior ot, heel or genitalia (Anaes.) (Assist.)	
Fee: \$458.30	Benefit: 75% = \$343.75		
FREE GRAFTING (Assist.)	(split skin) to burns, includ	ing excision of burnt tissue - whole of toe (Anaes.)	
Fee: \$412.55	Benefit: 75% = \$309.45	5% = \$350.70	
		ng excision of burnt tissue - the whole of 1 digit of the	
Fee: \$458.30	Benefit: 75% = \$343.75		
	· •	ing excision of burnt tissue - the whole of 2 digits of the	
Fee: \$687.65	Benefit: 75% = \$515.75 8	5% = \$602.95	
		ing excision of burnt tissue - the whole of 3 digits of the	
Fee: \$916.95	Benefit: 75% = \$687.75		
		ng excision of burnt tissue - the whole of 4 digits of the	
Fee: \$1,146.10	Benefit: 75% = \$859.60		
		ng excision of burnt tissue - the whole of 5 digits of the	
Fee: \$1,375.25	Benefit: 75% = \$1031.45		
FREE GRAFTING (Anaes.) (Assist.)	(split skin) to burns, includ	ng excision of burnt tissue - portion of digit of hand	
. , . ,			
	 (Assist.) Fee: \$3,772.00 FREE GRAFTING more but less than Fee: \$2,845.90 FREE GRAFTING more of total body Fee: \$4,297.65 FREE GRAFTING more of total body Fee: \$4,297.65 FREE GRAFTING more of total body Fee: \$3,242.55 FREE GRAFTING or palm of the hand Fee: \$536.15 FREE GRAFTING aspect of the neck, Fee: \$458.30 FREE GRAFTING (Assist.) Fee: \$412.55 FREE GRAFTING hand (Anaes.) (Assist.) Fee: \$458.30 FREE GRAFTING hand (Anaes.) (Assist.) Fee: \$1,146.10 FREE GRAFTING hand (Anaes.) (Assist.) Fee: \$1,375.25 FREE GRAFTING FREE GRAFTING FREE GRAFTING FREE GRAFTING FREE GRAFTING 	(Assist.)Fee: \$3,772.00Benefit: 75% = \$2829.00FREE GRAFTING (split skin) to burns, includi more but less than 80 percent of total body surfFee: \$2,845.90Benefit: 75% = \$2134.45FREE GRAFTING (split skin) to burns, includi more of total body surface - conjoint surgery, pFee: \$4,297.65Benefit: 75% = \$3223.25FREE GRAFTING (split skin) to burns, includi more of total body surface - conjoint surgery, cdFee: \$3,242.55Benefit: 75% = \$2431.95FREE GRAFTING (split skin) to burns, includi or palm of the hand (Anaes.) (Assist.)Fee: \$536.15Benefit: 75% = \$402.15FREE GRAFTING (split skin) to burns, includi aspect of the neck, chin, plantar aspect of the for Gere: \$458.30Benefit: 75% = \$309.458FREE GRAFTING (split skin) to burns, includi (Assist.)Fee: \$412.55Benefit: 75% = \$309.45FREE GRAFTING (split skin) to burns, includi (Assist.)Fee: \$458.30Benefit: 75% = \$343.75FREE GRAFTING (split skin) to burns, includi hand (Anaes.) (Assist.)Fee: \$458.30Benefit: 75% = \$343.75FREE GRAFTING (split skin) to burns, includi hand (Anaes.) (Assist.)Fee: \$687.65Benefit: 75% = \$343.75FREE GRAFTING (split skin) to burns, includi hand (Anaes.) (Assist.)Fee: \$916.95Benefit: 75% = \$687.75FREE GRAFTING (split skin) to burns, includi hand (Anaes.) (Assist.)Fee: \$1,146.10Benefit: 75% = \$1031.45Free: \$1,375.25Benefit: 75% = \$1031.45FREE GRAFTING (split skin) to burns, includi hand (Anaes.) (Assist.)Fee: \$1,375.2	

T8. SUF	GICAL OPERATION	DNS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	FREE GRAFTING ears) (Anaes.) (As	G (split skin) to burns, including excision of burnt tissue - whole of face (excluding sist.)
45494	Fee: \$1,664.90	Benefit: 75% = \$1248.70 85% = \$1580.20
		OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
	FLAP, free tissue	transfer using microvascular techniques - revision of, by open operation (Anaes.)
45496	Fee: \$422.70	Benefit: 75% = \$317.05
		transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>of</i> , by liposuction (Anaes.)
45497	Fee: \$330.15	Benefit: 75% = \$247.65
		transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - by liposuction - first stage (Anaes.)
45498	Fee: \$265.75	Benefit: 75% = \$199.35
		transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - by liposuction - second stage (Anaes.)
45499	Fee: \$198.10	Benefit: 75% = \$148.60
		AR REPAIR using microsurgical techniques, with restoration of continuity of artery atremity or digit (Anaes.) (Assist.)
45500	Fee: \$1,107.80	Benefit: 75% = \$830.85
	MICROVASCUL limb or digit (Ana	AR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of es.) (Assist.)
45501	Fee: \$1,803.10	Benefit: 75% = \$1352.35
	MICROVASCUL limb or digit (Ana	AR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of es.) (Assist.)
45502	Fee: \$1,803.10	Benefit: 75% = \$1352.35
	MICRO-ARTERI	AL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.)
45503	Fee: \$2,062.85	Benefit: 75% = \$1547.15
		AR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tting in of free flap (Anaes.) (Assist.)
45504	Fee: \$1,803.10	Benefit: 75% = \$1352.35
		AR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tting in of free flap (Anaes.) (Assist.)
45505	Fee: \$1,803.10	Benefit: 75% = \$1352.35
		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.)
45506	(See para TN.8.95 o Fee: \$223.45	f explanatory notes to this Category) Benefit: $75\% = \$167.60$ $85\% = \$189.95$
45512	SCAR, of face or	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.)

T8. SUF	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	(See para TN.8.95 of explanatory notes to this Category) Fee: \$300.45 Benefit: 75% = \$225.35 85% = \$255.40		
	SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or where performed by a specialist in the practice of his or her specialty (Anaes.)		
45515	(See para TN.8.95 of explanatory notes to this Category)Fee: $$189.50$ Benefit: $75\% = 142.15 $85\% = 161.10		
	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her speciality (Anaes.)		
45518	(See para TN.8.95 of explanatory notes to this Category)Fee: $$229.30$ Benefit: $75\% = 172.00 $85\% = 194.95		
	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.)		
45519	Fee: \$435.90 Benefit: 75% = \$326.95		
	Reduction mammaplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast (Anaes.) (Assist.)		
45520	Fee: \$914.85 Benefit: 75% = \$686.15		
	Reduction mammaplasty (unilateral) without surgical repositioning of the nipple:		
	(a) excluding the treatment of gynaecomastia; and		
	(b) not with insertion of any prosthesis (Anaes.) (Assist.)		
45522	Fee: \$641.85 Benefit: 75% = \$481.40		
	Reduction mammaplasty (bilateral) with surgical repositioning of the nipple:		
	(a) for patients with macromastia and experiencing pain in the neck or shoulder region; and		
	(b) not with insertion of any prosthesis (Anaes.) (Assist.)		
45523	Fee: \$1,372.30 Benefit: 75% = \$1029.25		
	Mammaplasty, augmentation (unilateral) in the context of:		
	(a) breast cancer; or		
	(b) developmental abnormality of the breast, if there is a difference in breast volume, as demonstrated 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.		
	Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)		
45524	(See para TN.8.96 of explanatory notes to this Category) Fee: \$753.50 Benefit: 75% = \$565.15		
45527	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis (Anaes.) (Assist.)		

RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGER'
(See para TN.8.96 of explanatory notes to this Category) Fee: \$753.50 Benefit: 75% = \$565.15
Mammaplasty, augmentation, bilateral (other than a service to which item 45527 applies), if:
(a) reconstructive surgery is indicated because of:
(i) developmental malformation of breast tissue (excluding hypomastia); or
(ii) disease of or trauma to the breast (other than trauma resulting from previous elective cosmetic surgery); or
(iii) amastia secondary to a congenital endocrine disorder; and
(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)
(See para TN.8.96 of explanatory notes to this Category) Fee: \$1,130.15 Benefit: 75% = \$847.65
Breast reconstruction (unilateral), using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177 or 30179 applies
(H) (Anaes.) (Assist.)
(See para TN.8.97 of explanatory notes to this Category) Fee: \$1,117.00 Benefit: 75% = \$837.75
BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Anaes.) (Assist.)
(See para TN.8.8 of explanatory notes to this Category) Fee: \$1,265.00 Benefit: 75% = \$948.75
BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.)
Fee: \$465.20 Benefit: 75% = \$348.90
BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.)
Fee: \$1,088.35 Benefit: 75% = \$816.30
BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal o tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.)
Fee: \$623.20 Benefit: 75% = \$467.40
NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.)
(See para TN.8.100 of explanatory notes to this Category) Fee: $\$632.50$ Benefit: $75\% = \$474.40$ $85\% = \$547.80$
Extended Medicare Safety Net Cap: \$506.00
NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	(See para TN.8.100 of explanatory not Fee: \$201.00 Benefit: 75%	es to this Category) = \$150.75 85% = \$170.85	
	BREAST PROSTHESIS, removal	of, as an independent procedure (Anaes.)	
45548	Fee: \$281.25 Benefit: 75%	= \$210.95 85% = \$239.10	
		excision of at least half of the fibrous capsule, not with insertion of then must be sent for histopathology and the volume removed must be report (Anaes.) (Assist.)	
45551	Fee: \$450.80 Benefit: 75%	= \$338.10	
		eplacement with another prosthesis, following medical complications c material or symptomatic capsular contracture), if:	
	(a) either:		
	(i) it is demonstrated by intra- unacceptable deformity; or	-operative photographs post-removal that removal alone would cause	
	(ii) the original implant was i and	nserted in the context of breast cancer or developmental abnormality;	
	(b) photographic and/or diagnostic documented in the patient notes (A	imaging evidence demonstrating the clinical need for this service is naes.) (Assist.)	
45553	(See para TN.8.98 of explanatory notes to this Category)Fee: \$580.75Benefit: 75% = \$435.60		
	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), including excision of at least half of the fibrous capsule or formation of a new pocket, or both, if:		
	(a) either:		
	(i) it is demonstrated by intra- unacceptable deformity; or	-operative photographs post-removal that removal alone would cause	
(ii) the original implant was inserted in the context of breast cancer or and		nserted in the context of breast cancer or developmental abnormality;	
	(b) the excised specimen is sent for histopathology and the volume removed is documented i histopathology report; and		
	(c) photographic and/or diagnostic documented in the patient notes (A	imaging evidence demonstrating the clinical need for this service is naes.) (Assist.)	
45554	(See para TN.8.98 of explanatory notes to this Category) Fee: \$710.65 Benefit: 75% = \$533.00		
	photographic evidence (including a	eral), in the context of breast cancer or developmental abnormality, if anterior, left lateral and right lateral views) and/or diagnostic imaging l need for this service is documented in the patient notes	
	Applicable only once per occasion	on which the service is provided (Anaes.) (Assist.)	
45556	(See para TN.8.99 of explanatory notes Fee: \$778.30 Benefit: 75%		

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Breast ptosis, correction by maste	opexy of (bilateral), if:
	(a) at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mamm where the nipple is located at the most dependent, inferior part of the breast contour; and	
	(b) if the patient has been pregnant—the correction is performed not less than 1 year, or more than years, after completion of the most recent pregnancy of the patient; and	
		ding anterior, left lateral and right lateral views), with a marker at the demonstrating the clinical need for this service, is documented in the
	Applicable only once per lifetime	e (Anaes.) (Assist.)
45558	(See para TN.8.99 of explanatory no Fee: \$1,167.35 Benefit: 75%	
		or the treatment of alopecia of congenital or traumatic origin or due to aldness, not being a service to which another item in this Group applies
45560	Fee: \$481.25Benefit: 759Extended Medicare Safety Net	% = \$360.95 85% = \$409.10 Cap: \$168.45
	MICROVASCULAR ANASTON supercharging of pedicled flaps (MOSIS of artery or vein using microsurgical techniques, for Anaes.) (Assist.)
45561	Fee: \$1,803.10 Benefit: 759	% = \$1352.35
		involving raising of tissue on vascular or neurovascular pedicle, ary cutaneous defect if performed, excluding flap for male pattern
45562	Fee: \$1,117.00 Benefit: 750	% = \$837.75 85% = \$1032.30
		FLAP, including direct repair of secondary cutaneous defect if le pattern baldness (Anaes.) (Assist.)
45563	Fee: \$1,117.00 Benefit: 759	% = \$837.75 85% = \$1032.30
	deformity, surgery or trauma, inv and including raising of tissue on transfer of tissue, insetting of tiss performed, other than a service a	tive surgery for the repair of major tissue defect due to congenital olving anastomoses of up to 2 vessels using microvascular techniques a vascular or neurovascular pedicle, preparation of recipient vessels, ue 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.)
45564	(See para TN.8.8 of explanatory notes to this Category) Fee: $$2,587.05$ Benefit: $75\% = 1940.30	
4555	deformity, surgery or trauma, inv and including raising of tissue on transfer of tissue, insetting of tiss performed, other than a service a	tive surgery for the repair of major tissue defect due to congenital olving anastomoses of up to 2 vessels using microvascular techniques a vascular or neurovascular pedicle, preparation of recipient vessels, ue 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
45565		

T8. SUF	GICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	(See para TN.8.8 of Fee: \$1,940.35	explanatory notes to this Category) Benefit: 75% = \$1455.30	
		SION not being a service to which item 45539 or 45542 applies - insertion of tissue d all attendances for subsequent expansion injections (Anaes.) (Assist.)	
45566	Fee: \$1,088.35	Benefit: 75% = \$816.30	
	TISSUE EXPAN	DER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.)	
45568	Fee: \$450.80	Benefit: 75% = \$338.10	
		BDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, sociated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.)	
45569	Fee: \$688.45	Benefit: 75% = \$516.35	
	CLOSURE OF A 45569 (Anaes.) (A	BDOMEN, repair of musculoaponeurotic layer, being a service associated with item Assist.)	
45570	Fee: \$929.60	Benefit: 75% = \$697.20 85% = \$844.90	
	service to which a	IVE TISSUE EXPANSION performed during an operation when combined with a nother item in Group T8 applies including expansion injections and excluding pattern baldness (Anaes.)	
45572	Fee: \$296.35	Benefit: 75% = \$222.30 85% = \$251.90	
	FACIAL NERVE	PARALYSIS, free fascia graft for (Anaes.) (Assist.)	
45575	Fee: \$731.70	Benefit: 75% = \$548.80 85% = \$647.00	
	FACIAL NERVE	PARALYSIS, muscle transfer for (Anaes.) (Assist.)	
45578	Fee: \$847.40	Benefit: 75% = \$635.55	
	FACIAL NERVE	PALSY, excision of tissue for (Anaes.)	
45581	Fee: \$281.25	Benefit: 75% = \$210.95 85% = \$239.10	
	Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), for treatment of post traumatic pseudolipoma, if photographic and/or diagnostic imaging evidence demonstrating the clinica need for this service is documented in the patient notes (Anaes.)		
45584	(See para TN.8.8, T Fee: \$641.85	N.8.101 of explanatory notes to this Category) Benefit: 75% = \$481.40	
		on assisted lipolysis) to one regional area (one limb or trunk), other than a service service to which item 31525 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 disor treatment of a medical condition; and		ction of a buffalo hump that is secondary to an endocrine disorder or pharmacological a medical condition; and	
		and/or diagnostic imaging evidence demonstrating the clinical need for this service is e patient notes (Anaes.)	
45585	(See para TN.8.8, T Fee: \$641.85	N.8.101 of explanatory notes to this Category) Benefit: 75% = \$481.40	

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Meloplasty for correction	of facial asymmetry if:
		ondary to trauma (including previous surgery), a congenital condition or a as facial nerve palsy); and
	(b) the meloplasty is limited to one side of the face (Anaes.) (Assist.)	
45587		natory notes to this Category) efit: 75% = \$678.85
	Meloplasty (excluding br	owlifts and chinlift platysmaplasties), bilateral, if:
		o correct a functional impairment due to a congenital condition, disease rring) or trauma (other than trauma resulting from previous elective cosmetic
	(b) photographic and/or of documented in the patien	liagnostic imaging evidence demonstrating the clinical need for this service is t notes (Anaes.) (Assist.)
45588	Fee: \$1,357.80 Ber	unatory notes to this Category) efit: 75% = \$1018.35
	ORBITAL CAVITY, rec	onstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.)
45590	Fee: \$491.00 Ber	efit: 75% = \$368.25
	ORBITAL CAVITY, bottom entrapped orbital content	ne or cartilage graft to orbital wall or floor including reduction of prolapsed or s (Anaes.) (Assist.)
45593	Fee: \$576.75 Ben	efit: 75% = \$432.60
	MAXILLA, total resection	on of (Anaes.) (Assist.)
45596	Fee: \$914.85 Ben	efit: 75% = \$686.15
	MAXILLA, total resection	on of both maxillae (Anaes.) (Assist.)
45597	Fee: \$1,224.70 Ben	efit: 75% = \$918.55
	MANDIBLE, total resect	ion of both sides, including condylectomies where performed (Anaes.) (Assist.)
45599	Fee: \$951.55 Ben	efit: 75% = \$713.70 85% = \$866.85
		ower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.)
45602	Fee: \$710.65 Ben	efit: 75% = \$533.00
		LLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.)
45605	Fee: \$597.00 Ben	efit: 75% = \$447.75
	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.)	
45608	Fee: \$840.55 Ben	efit: 75% = \$630.45
	MANDIBLE, condylecto	my (Anaes.) (Assist.)
45611	Fee: \$481.35 Ben	efit: 75% = \$361.05
	EYELID, WHOLE THIC	CKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.)
45614	(Assist.)	

T8. SUF	RGICAL OPERATIONS 13.	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$597.00 Benefit: 75% = \$447.75 85% = Extended Medicare Safety Net Cap: \$477.60	= \$512.30	
	Upper eyelid, reduction of, if:		
	(a) the reduction is for any of the following:		
	(i) skin redundancy that causes a visual field of ophthalmologist) or intertriginous inflammation		
	(ii) herniation of orbital fat in exophthalmos;		
	(iii) facial nerve palsy;		
	(iv) post-traumatic scarring;		
	(v) the restoration of symmetry of contralatera mentioned in subparagraphs (i) to (iv); and	l upper eyelid in respect of one of the conditions	
	(b) photographic and/or diagnostic imaging evidence documented in the patient notes (Anaes.)	e demonstrating the clinical need for this service is	
45617	(See para TN.8.103 of explanatory notes to this Category Fee: \$238.80 Benefit: 75% = \$179.10 85% = Extended Medicare Safety Net Cap: \$191.05		
	Lower eyelid, reduction of, if:		
	(a) the reduction is for:		
	(i) herniation of orbital fat in exophthalmos, fa	acial nerve palsy or post-traumatic scarring; or	
	(ii) the restoration of symmetry of the contrala conditions; and	teral lower eyelid in respect of one of these	
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this documented in the patient notes (Anaes.)		
45620	(See para TN.8.103 of explanatory notes to this Category Fee: \$331.25 Benefit: 75% = \$248.45 85% = Extended Medicare Safety Net Cap: \$265.00		
	Ptosis of upper eyelid (unilateral), correction of, by		
	(a) sutured elevation of the tarsal plate on the eyelic aponeurosis); or	retractors (Muller's or levator muscle or levator	
	(b) sutured suspension to the brow/frontalis muscle;		
	Not applicable to a service for repair of mechanical ptosis to which item 45617 applies (A		
45623	Fee: \$734.60 Benefit: 75% = \$550.95 85% = Extended Medicare Safety Net Cap: \$587.70	= \$649.90	
	Ptosis of upper eyelid, correction of, by:		
45624	(a) sutured elevation of the tarsal plate on the eyelic aponeurosis); or	retractors (Muller's or levator muscle or levator	

T8. SUR	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	(b) sutured suspension to the brow/frontalis muscle;		
	if a previous ptosis surgery has been performed on that side (Anaes.) (Assist.)		
	Fee: \$952.40 Benefit: 75% = \$714.30 85% = \$867.70 Extended Medicare Safety Net Cap: \$761.95		
	PTOSIS of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital (Anaes.)		
45625	Fee: \$190.55 Benefit: 75% = \$142.95		
	Ectropion or entropion, not caused by trachoma, correction of (unilateral) (Anaes.)		
45626	Fee: \$331.25 Benefit: 75% = \$248.45 85% = \$281.60		
	Ectropion or entropion, caused by trachoma, correction of (unilateral) (Anaes.)		
45627 S	Fee: \$331.25 Benefit: 75% = \$248.45 85% = \$281.60		
	SYMBLEPHARON, grafting for (Anaes.) (Assist.)		
45629	Fee: \$481.35 Benefit: 75% = \$361.05 85% = \$409.15		
	Rhinoplasty, partial, involving correction of lateral or alar cartilages, if:		
	(a) the indication for surgery is:		
	(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or		
	(ii) significant acquired, congenital or developmental deformity; and		
	(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)		
45632	(See para TN.8.104 of explanatory notes to this Category) Fee: \$520.15 Benefit: 75% = \$390.15 85% = \$442.15 Extended Medicare Safety Net Cap: \$416.15		
	Rhinoplasty, partial, involving correction of bony vault only, if:		
	(a) the indication for surgery is:		
	(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or		
	(ii) significant acquired, congenital or developmental deformity; and		
	(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)		
45635	(See para TN.8.104 of explanatory notes to this Category) Fee: \$597.00 Benefit: 75% = \$447.75 85% = \$512.30 Extended Medicare Safety Net Cap: \$477.60		
-	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, with or without autogenous cartilage or bone graft from a local site (nasal), if:		
	(a) the indication for surgery is:		
45641	(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or		

T8. SUR	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	(ii) significant acquired, congenital	or developmental deformity; and	
	(b) photographic and/or NOSE Scale evi documented in the patient notes (Anaes.)	dence demonstrating the clinical need for this service is	
	(See para TN.8.104 of explanatory notes to th Fee: \$1,083.05 Benefit: 75% = \$812		
		of all bony and cartilaginous elements of the external nose graft obtained from distant donor site, including obtaining of	
	(a) the indication for surgery is:		
	(i) airway obstruction and the patie	ant has a self-reported NOSE Scale score of greater than 45; or	
	(ii) significant acquired, congenital	or developmental deformity; and	
	(b) photographic and/or NOSE Scale evi documented in the patient notes (Anaes.)	dence demonstrating the clinical need for this service is (Assist.)	
45644	(See para TN.8.104 of explanatory notes to th Fee: \$1,299.90 Benefit: 75% = \$974		
	CHOANAL ATRESIA, repair of by pun	cture and dilatation (Anaes.)	
45645	Fee: \$227.20 Benefit: 75% = \$170	0.40	
	CHOANAL ATRESIA - correction by o	pen operation with bone removal (Anaes.) (Assist.)	
45646	Fee: \$914.85 Benefit: 75% = \$680	6.15 85% = \$830.15	
	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.)		
45647	(See para TN.8.105 of explanatory notes to th Fee: \$1,299.90 Benefit: 75% = \$974		
	Rhinoplasty, revision of, if:		
	(a) the indication for surgery is:		
	(i) airway obstruction and the patie	nt has a self-reported NOSE Scale score of greater than 45; or	
	(ii) significant acquired, congenital	or developmental deformity; and	
	(b) photographic and/or NOSE Scale evi documented in the patient notes (Anaes.)	dence demonstrating the clinical need for this service is	
45650	(See para TN.8.104 of explanatory notes to th Fee: \$150.15 Benefit: 75% = \$112	nis Category) 2.65 85% = \$127.65	
	Rhinophyma of a moderate or severe deg (Anaes.)	gree, carbon dioxide laser or erbium laser excision - ablation of	
		1.55 85% = \$307.75	
45652	Extended Medicare Safety Net Can: \$	Extended Medicare Safety Net Cap: \$289.65 RHINOPHYMA, shaving of (Anaes.)	
45652	Extended Medicare Safety Net Cap: \$2 RHINOPHYMA, shaving of (Anaes.)	289.65	

T8. SUF	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGE	RY
	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist	i.)
45656	Fee: \$510.30 Benefit: 75% = \$382.75 85% = \$433.80	
	Correction of a congenital deformity of the ear if:	
	(a) the patient is less than 18 years of age; and	
	(b) the deformity is characterised by an absence of the antihelical fold and/or large scapha and/or large concha; and	e
	(c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	t
45659	Fee: \$529.60 Benefit: 75% = \$397.20	
	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, a congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.)	
45660	Fee: \$2,924.80 Benefit: 75% = \$2193.60	
	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fa flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.)	
45661	Fee: \$1,299.90 Benefit: 75% = \$974.95	
	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.)	
45662	Fee: \$712.50 Benefit: 75% = \$534.40	
	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes.)	
45665	Fee: \$331.25 Benefit: 75% = \$248.45 85% = \$281.60	
	VERMILIONECTOMY, by surgical excision (Anaes.)	
45668	Fee: \$331.25 Benefit: 75% = \$248.45 85% = \$281.60	
	Vermilionectomy for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser excision - ablation (Anaes.)	
45669	(See para TN.8.106 of explanatory notes to this Category) Fee: \$331.25 Benefit: 75% = \$248.45 85% = \$281.60	
	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)	
45671	Fee: \$847.40 Benefit: 75% = \$635.55 85% = \$762.70	
_	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.)	
45674	Fee: \$246.45 Benefit: 75% = \$184.85 85% = \$209.50	
	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.)	
45675	Fee: \$491.00 Benefit: 75% = \$368.25	

T8. SUF		IONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	MACROSTOMI	A, operation for (Anaes.) (Assist.)
45676	Fee: \$584.50	Benefit: 75% = \$438.40
	CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)	
45677	Fee: \$550.00	Benefit: 75% = \$412.50
	CLEFT LIP, unil	ateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)
45680	Fee: \$687.65	Benefit: 75% = \$515.75
	CLEFT LIP, bila	teral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)
45683	Fee: \$763.90	Benefit: 75% = \$572.95
	CLEFT LIP, bila	teral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)
45686	Fee: \$901.70	Benefit: 75% = \$676.30
	CLEFT LIP, lip a	adhesion procedure, unilateral or bilateral (Anaes.) (Assist.)
45689	Fee: \$265.95	Benefit: 75% = \$199.50
		ial revision, including minor flap revision alignment and adjustment, including revision deformity if performed (Anaes.)
45692	Fee: \$305.55	Benefit: 75% = \$229.20 85% = \$259.75
		l revision, including major flap revision, muscle reconstruction and revision of major y (Anaes.) (Assist.)
45695	Fee: \$496.55	Benefit: 75% = \$372.45
	CLEFT LIP, prin	nary columella lengthening procedure, bilateral (Anaes.)
45698	Fee: \$466.10	Benefit: 75% = \$349.60
	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)	
45701	Fee: \$840.55	Benefit: 75% = \$630.45
	CLEFT LIP REC	CONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.)
45704	Fee: \$305.55	Benefit: 75% = \$229.20 85% = \$259.75
	CLEFT PALATE, primary repair (Anaes.) (Assist.)	
45707 Fee: \$794.45 Benefit: 75% = \$595.85		Benefit: 75% = \$595.85
	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.)	
45710	Fee: \$496.55	Benefit: 75% = \$372.45
	CLEFT PALATE	E, secondary repair, lengthening procedure (Anaes.) (Assist.)
45713	Fee: \$565.50	Benefit: 75% = \$424.15
	ORO-NASAL Fl applies (Anaes.)	STULA, plastic closure of, including services to which item 45200, 45203 or 45239 (Assist.)
45714	Fee: \$794.45	Benefit: 75% = \$595.85

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	VELO-PHARYNGEAL INCOMPETEN	CE, pharyngeal flap for, or pharyngoplasty for (Anaes.)
45716	Fee: \$794.45 Benefit: 75% = \$595	85
		steotomy or osteectomy of, including transposition of nerves e same site and excluding services to which item 47933or
45720	(See para TN.8.107 of explanatory notes to the Fee: \$982.25 Benefit: 75% = \$736	
	and vessels and bone grafts taken from th	esteotomy or osteectomy of, including transposition of nerves e same site and stabilisation with fixation by wires, screws, cluding services to which item 47933 or 47936 apply (Anaes.)
45723	(See para TN.8.107 of explanatory notes to the Fee: \$1,107.80 Benefit: 75% = \$830	
		teotomy or osteectomy of, including transposition of nerves e same site, and excluding services to which item 47933 or
45726	(See para TN.8.107 of explanatory notes to thi Fee: \$1,251.75 Benefit: 75% = \$938	
	and vessels and bone grafts taken from th	teotomy or osteectomy of, including transposition of nerves e same site and stabilisation with fixation by wires, screws, cluding services to which item 47933 or 47936 apply (Anaes.)
45729	(See para TN.8.107 of explanatory notes to the Fee: \$1,405.80 Benefit: 75% = \$105	
		or osteectomies of, involving 3 or more such procedures on the nd vessels and bone grafts taken from the same site, and r 47936 apply (Anaes.) (Assist.)
45731	(See para TN.8.107 of explanatory notes to the Fee: \$1,425.15 Benefit: 75% = \$106	
	the 1 jaw, including transposition of nerve	s or osteectomies of, involving 3 or more such procedures on es and vessels and bone grafts taken from the same site and rs, plates or pins, or any combination, and excluding services to .) (Assist.)
45732	(See para TN.8.107 of explanatory notes to the Fee: \$1,604.45 Benefit: 75% = \$120	÷ •
		ies or osteectomies of, involving 2 such procedures of each vessels and bone grafts taken from the same site, and r 47936 apply (Anaes.) (Assist.)
45735	(See para TN.8.107 of explanatory notes to the Fee: \$1,636.85 Benefit: 75% = \$122	
45738	jaw, including transposition of nerves and	ies or osteectomies of, involving 2 such procedures of each vessels and bone grafts taken from the same site and s, plates or pins, or any combination, and excluding services to .) (Assist.)

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(See para TN.8.107 of explanatory note Fee: \$1,841.40 Benefit: 75% =	
	such procedures of 1 jaw and 2 such	mplex bilateral osteotomies or osteectomies of, involving 3 or more a procedures of the other jaw, including genioplasty when performed sels and bone grafts taken from the same site, and excluding services y (Anaes.) (Assist.)
45741	(See para TN.8.107 of explanatory note Fee: \$1,800.65 Benefit: 75% =	
	such procedures of 1 jaw and 2 such and transposition of nerves and vess	nplex bilateral osteotomies or osteectomies of, involving 3 or more a procedures of the other jaw, including genioplasty when performed sels and bone grafts taken from the same site and stabilisation with pins, or any combination, and excluding services to which item sist.)
45744	(See para TN.8.107 of explanatory note Fee: \$2,024.60 Benefit: 75% =	
	such procedures of each jaw, includ	nplex bilateral osteotomies or osteectomies of, involving 3 or more ing genioplasty (when performed) and transposition of nerves and the same site, and excluding services to which item 47933 or 47936
45747	(See para TN.8.107 of explanatory note Fee: \$1,964.50 Benefit: 75% =	s to this Category) = \$1473.40 85% = \$1879.80
	such procedures of each jaw, includ vessels and bone grafts taken from t	nplex bilateral osteotomies or osteectomies of, involving 3 or more ing genioplasty when performed and transposition of nerves and the same site and stabilisation with fixation by wires, screws, plates cluding services to which item 47933 or 47936 apply (Anaes.)
45752	(See para TN.8.107 of explanatory note Fee: \$2,200.40 Benefit: 75% =	
	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III(Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	
45753	Fee: \$2,213.45 Benefit: 75% =	= \$1660.10 85% = \$2128.75
	(Malar-Maxillary), Le Fort III invol	e Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III ving 3 or more osteotomies of the midface including transposition of aken from the same site and stabilisation with fixation by wires, nation (Anaes.) (Assist.)
45754	Fee: \$2,653.40 Benefit: 75% =	= \$1990.05
	TEMPOROMANDIBULAR PART	TAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.)
45755	Fee: \$373.65 Benefit: 75% =	= \$280.25 85% = \$317.65
	TEMPORO-MANDIBULAR JOIN	T, arthroplasty (Anaes.) (Assist.)
45758	Fee: \$668.60 Benefit: 75% =	= \$501.45
		sition of nerves and vessels and bone grafts taken from the same site
45761		

T8. SURGICAL OPERATIONS		ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	(See para TN.8.108 Fee: \$760.65	3 of explanatory notes to this Category) Benefit: 75% = \$570.50	
	HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.)		
45767	Fee: \$2,551.85	Benefit: 75% = \$1913.90 85% = \$2467.15	
	HYPERTELORI	SM, correction of, subcranial (Anaes.) (Assist.)	
45770	Fee: \$1,954.70	Benefit: 75% = \$1466.05	
	TREACHER CO grafts (Anaes.) (A	LLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone Assist.)	
45773	Fee: \$1,781.45	Benefit: 75% = \$1336.10 85% = \$1696.75	
	ORBITAL DYST intracranial (Ana	FOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, es.) (Assist.)	
45776	Fee: \$1,781.45	Benefit: 75% = \$1336.10	
	ORBITAL DYST extracranial (Ana	TOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, les.) (Assist.)	
45779	Fee: \$1,309.80	Benefit: 75% = \$982.35	
	FRONTOORBIT	AL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.)	
45782	Fee: \$1,001.45	Benefit: 75% = \$751.10 85% = \$916.75	
		LT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar ral frontoorbital advancement) (Anaes.) (Assist.)	
45785	Fee: \$1,694.80	Benefit: 75% = \$1271.10	
		SA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, nique) (Anaes.) (Assist.)	
45788	Fee: \$1,675.50	Benefit: 75% = \$1256.65	
	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION (not including harvesting of graft material (Anaes.) (Assist.)		
45791	Fee: \$905.10	Benefit: 75% = \$678.85	
	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.)		
45794	Fee: \$511.90	Benefit: 75% = \$383.95 85% = \$435.15	
	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment, not for implantable be conduction hearing system device (Anaes.)		
45797	Fee: \$189.50	Benefit: 75% = \$142.15 85% = \$161.10	
	ORAL AND MAXILLOFACIAL SURGERY		
		IOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for ses and not being a service associated with an operative procedure on the same day	
45799	Fee: \$29.90	Benefit: 75% = \$22.45 85% = \$25.45	
45801	TUMOUR, CYS'	T, ULCER OR SCAR, (other than a scar removed during the surgical approach at an	

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
		egion, up to 3 cm in diameter, removal from cutaneous or nbrane, where the removal is by surgical excision and suture, applies (Anaes.)	
	(See para TN.8.109 of explanatory notes to th Fee: \$128.95 Benefit: 75% = \$96.		
	an operation), in the oral and maxillofaci subcutaneous tissue or from mucous mer	ARS, (other than a scar removed during the surgical approach at fal region, up to 3 cm in diameter, removal from cutaneous or nbrane, where the removal is by surgical excision and suture, than 3 but not more than 10 lesions (Anaes.) (Assist.)	
45803	(See para TN.8.109 of explanatory notes to th Fee: \$331.25 Benefit: 75% = \$248	nis Category) 8.45 85% = \$281.60	
		(other than a scar removed during the surgical approach at an region, more than 3 cm in diameter, removal from cutaneous or mbrane (Anaes.)	
45805	(See para TN.8.109 of explanatory notes to th Fee: \$175.25 Benefit: 75% = \$13	nis Category) 1.45 85% = \$149.00	
	established by radiological examination t lining and tooth structure or where a turn ULCER OR SCAR (other than a scar rer	bociated with a tooth or tooth fragment unless it has been that there is a minimum of 5mm separation between the cyst iour or cyst has been proven by positive histopathology), noved during the surgical approach at an operation), in the oral t being a service to which another item in this Subgroup applies, issue (Anaes.)	
45807	(See para TN.8.109 of explanatory notes to th Fee: \$250.45 Benefit: 75% = \$18°	nis Category) 7.85 85% = \$212.90	
	been established by radiological examination cyst lining and tooth structure or where a	a cyst associated with a tooth or tooth fragment unless it has ation that there is a minimum of 5mm separation between the a tumour or cyst has been proven by positive histopathology), in al of, requiring wide excision, not being a service to which naes.) (Assist.)	
45809	(See para TN.8.109 of explanatory notes to th Fee: \$377.45 Benefit: 75% = \$283	nis Category) 3.10 85% = \$320.85	
		region, removal of, from soft tissue (including muscle, fascia n of, without skin or mucosal graft (Anaes.) (Assist.)	
45811	(See para TN.8.109 of explanatory notes to the Fee: \$510.30 Benefit: 75% = \$382	nis Category) 2.75 85% = \$433.80	
	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.)		
45813	(See para TN.8.109 of explanatory notes to th Fee: \$597.00 Benefit: 75% = \$44'	nis Category) 7.75 85% = \$512.30	
	OPERATION ON MANDIBLE OR MA - 1 bone or in combination with adjoining	XILLA (other than alveolar margins) for chronic osteomyelitis g bones (Anaes.) (Assist.)	
45815	Fee: \$362.05 Benefit: 75% = \$27	1.55 85% = \$307.75	
	OPERATION on SKULL for OSTEOM	YELITIS (Anaes.) (Assist.)	

T8. SURGICAL OPERATIONS		DNS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
		ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND AL REGION, being bones referred to in item 45817 (Anaes.) (Assist.)	
45819	Fee: \$596.95	Benefit: 75% = \$447.75 85% = \$512.25	
	BONE GROWTH (Anaes.) (Assist.)	STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of	
45821	Fee: \$386.90	Benefit: 75% = \$290.20 85% = \$328.90	
		or more, which were inserted for dental fixation purposes to the maxilla or mandible, ing general anaesthesia where undertaken in the operating theatre of a hospital	
45823	Fee: \$110.65	Benefit: 75% = \$83.00	
	MANDIBULAR	OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.)	
45825	Fee: \$343.75	Benefit: 75% = \$257.85 85% = \$292.20	
	MYLOHYOID R	IDGE, reduction of (Anaes.) (Assist.)	
45827	Fee: \$328.55	Benefit: 75% = \$246.45 85% = \$279.30	
		JBEROSITY, reduction of (Anaes.)	
45829	Fee: \$250.65	Benefit: 75% = \$188.00 85% = \$213.10	
-5027		PERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.)	
45021			
45831	Fee: \$328.55	Benefit: 75% = \$246.45 85% = \$279.30 PERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.)	
	r AFILLAR I II I	ERFLASIA OF THE FALATE, TEMOVALOF - 5 to 20 lesions (Anaes.) (Assist.)	
45833	Fee: \$412.55	Benefit: 75% = \$309.45 85% = \$350.70	
	PAPILLARY HY	PERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.)	
45835	Fee: \$511.90	Benefit: 75% = \$383.95 85% = \$435.15	
	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.)		
45837	Fee: \$595.90	Benefit: 75% = \$446.95 85% = \$511.20	
	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.)		
45839	Fee: \$595.90	Benefit: 75% = \$446.95 85% = \$511.20	
	ALVEOLAR RID	GE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.)	
45841	Fee: \$481.25	Benefit: 75% = \$360.95 85% = \$409.10	
		GE AUGMENTATION - unilateral, insertion of tissue expanding device into libular alveolar ridge region for (Anaes.) (Assist.)	
45843	Fee: \$295.15	Benefit: 75% = \$221.40 85% = \$250.90	
		ATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate dentition following resection of part of the maxilla or mandible for benign or s (Anaes.)	
45845	Fee: \$511.90	Benefit: 75% = \$383.95 85% = \$435.15	

T8. SUF	GICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
		ATION PROCEDURE - fixation of transmucosal abutment to fixtures placed n of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	
45847	Fee: \$189.50	Benefit: 75% = \$142.15 85% = \$161.10	
		NUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining ire), (unilateral) (Anaes.) (Assist.)	
45849	Fee: \$590.20	Benefit: 75% = \$442.65 85% = \$505.50	
		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.)	
45851	Fee: \$145.25	Benefit: 75% = \$108.95	
		YLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not ng of graft material (Anaes.) (Assist.)	
45853	Fee: \$905.10	Benefit: 75% = \$678.85 85% = \$820.40	
		DIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service any other arthroscopic procedure of that joint (Anaes.) (Assist.)	
45855	Fee: \$415.25	Benefit: 75% = \$311.45 85% = \$353.00	
	DIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment r more such procedure of that joint, not being a service associated with any other edure of the temporomandibular joint (Anaes.) (Assist.)		
45857	Fee: \$664.25	Benefit: 75% = \$498.20 85% = \$579.55	
		DIBULAR JOINT, arthrotomy of, not being a service to which another item in this (Anaes.) (Assist.)	
45859	Fee: \$334.85	Benefit: 75% = \$251.15 85% = \$284.65	
	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)		
45861	Fee: \$886.25	Benefit: 75% = \$664.70 85% = \$801.55	
	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.)		
45863	Fee: \$982.45	Benefit: 75% = \$736.85 85% = \$897.75	
	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.)		
45865	Fee: \$295.15	Benefit: 75% = \$221.40 85% = \$250.90	
	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)		
45867	Fee: \$317.30	Benefit: 75% = \$238.00 85% = \$269.75	
	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.)		
45869	Fee: \$1,207.20	Benefit: 75% = \$905.40 85% = \$1122.50	
45871		DIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar	

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	head surgery, with or without microsurgical tec	chniques (Anaes.) (Assist.)	
	Fee: \$1,359.85 Benefit: 75% = \$1019.90	85% = \$1275.15	
		f, involving procedures to which items 45863, 45867, use of tissue flaps, or cartilage graft, or allograft implants, es.) (Assist.)	
45873	Fee: \$1,528.10 Benefit: 75% = \$1146.10	85% = \$1443.40	
		ion of, involving 1 or more of: repair of capsule, repair of e to which another item in this Subgroup applies (Anaes.)	
45875	Fee: \$478.25 Benefit: 75% = \$358.70 §	35% = \$406.55	
	TEMPOROMANDIBULAR JOINT, arthrodes to which another item in this Subgroup applies	is of, with synovectomy if performed, not being a service (Anaes.) (Assist.)	
45877	Fee: \$478.25 Benefit: 75% = \$358.70 §	35% = \$406.55	
	TEMPOROMANDIBULAR JOINT OR JOINT treatment of fractures (Anaes.) (Assist.)	TS, application of external fixator to, other than for	
45879	Fee: \$317.30 Benefit: 75% = \$238.00 8	85% = \$269.75	
	The treatment of a premalignant lesion of the o or carbon dioxide laser.	ral mucosa by a treatment using cryotherapy, diathermy	
45882	Fee: \$43.70 Benefit: 75% = \$32.80 85	5% = \$37.15	
	Facial, mandibular or lingual artery or vein or a item 41707 applies (Anaes.) (Assist.)	artery and vein, ligation of, not being a service to which	
45885	Fee: \$450.80 Benefit: 75% = \$338.10 8	85% = \$383.20	
	FOREIGN BODY, in the oral and maxillofacia techniques (Anaes.) (Assist.)	ll region, deep, removal of using interventional imaging	
45888	Fee: \$420.15 Benefit: 75% = \$315.15 8	85% = \$357.15	
	SINGLE-STAGE LOCAL FLAP where indica (Assist.)	ted, repair to 1 defect, using temporalis muscle (Anaes.)	
45891	Fee: \$612.10 Benefit: 75% = \$459.10 8	85% = \$527.40	
	FREE GRAFTING, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area (Anaes.)		
45894	Fee: \$208.00 Benefit: 75% = \$156.00 \$	35% = \$176.80	
	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro- nasal fistulae and ridge augmentation (Anaes.) (Assist.)		
45897	Fee: \$1,086.20 Benefit: 75% = \$814.65 8	85% = \$1001.50	
	MANDIBLE, fixation by intermaxillary wiring	, excluding wiring for obesity	
45900	Fee: \$245.00 Benefit: 75% = \$183.75	85% = \$208.25	
		MINAL NERVE, cryosurgery of, for pain relief (Anaes.)	
45939			

T8. SUF	18. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$454.25	Benefit: 75% = \$340.70	85% = \$386.15	
	MANDIBLE, treat	ment of a dislocation of, i	requiring open reduction (Anaes.)	
45945	Fee: \$120.60	Benefit: 75% = \$90.45	85% = \$102.55	
	MAXILLA, unilate	eral or bilateral, treatment	t of fracture of, not requiring splinting	
45975	(See para TN.8.110 c Fee: \$131.25	of explanatory notes to this C Benefit: 75% = \$98.45		
	MANDIBLE, treat	ment of fracture of, not re	equiring splinting	
45978	(See para TN.8.110 o Fee: \$160.40	of explanatory notes to this C Benefit: 75% = \$120.30		
	ZYGOMATIC BO	NE, treatment of fracture	of, not requiring surgical reduction	
45981	(See para TN.8.110 c Fee: \$87.00	of explanatory notes to this C Benefit: 75% = \$65.25		
		ent of a complicated fraction involving plate(s) (Anaes	ture of, involving viscera, blood vessels or nerves requiring s.) (Assist.)	
45984	(See para TN.8.110 c Fee: \$626.50	of explanatory notes to this C Benefit: 75% = \$469.90		
		ment of a complicated fra action not involving plate	acture of, involving viscera, blood vessels or nerves, (s) (Anaes.) (Assist.)	
45987	(See para TN.8.110 c Fee: \$626.50	of explanatory notes to this C Benefit: 75% = \$469.90		
		ent of a complicated fractory of the use of plate(s)	ture of, involving viscera, blood vessels or nerves requiring (Anaes.) (Assist.)	
45990	(See para TN.8.110 c Fee: \$855.75	of explanatory notes to this C Benefit: 75% = \$641.85		
		1	acture of, involving viscera, blood vessels or nerves, f plate(s) (Anaes.) (Assist.)	
45993		of explanatory notes to this C Benefit: 75% = \$641.85		
	MANDIBLE, treat	ment of a closed fracture	of, involving a joint surface (Anaes.)	
45996	(See para TN.8.110 c Fee: \$242.60	of explanatory notes to this C Benefit: 75% = \$181.95		
T8. SUF		NS	14. HAND SURGERY	
	Group T8. Surgica	al Operations		
		Sub	group 14. Hand Surgery	
	Note: Items 46300	to 46534 are restricted to	surgery on the hand/s.	
46300	INTER-PHALAN	GEAL JOINT or METAC	CARPOPHALANGEAL JOINT, arthrodesis of, with	

T8. SUF	GICAL OPERATIO	DNS	14. HAND SURGERY
	synovectomy if pe	rformed (Anaes.) (Assist.)	
	Fee: \$343.80	Benefit: 75% = \$257.85	
	CARPOMETACA	RPAL JOINT, arthrodesis of, with syno	vectomy if performed (Anaes.) (Assist.)
46303	Fee: \$382.10	Benefit: 75% = \$286.60	
		GEAL JOINT or METACARPOPHALA on transfers or realignment on the 1 ray	NGEAL JOINT, interposition arthroplasty of (Anaes.) (Assist.)
46306	Fee: \$534.90	Benefit: 75% = \$401.20	
		GEAL JOINT OR METACARPOPHALA y including tendon transfers or realignm	ANGEAL JOINT - volar plate arthroplasty for ent on the 1 ray (Anaes.) (Assist.)
46307	Fee: \$534.90	Benefit: 75% = \$401.20	
			NGEAL JOINT, total replacement novectomy, tendon transfer or realignment -
46309	Fee: \$534.90	Benefit: 75% = \$401.20	
			NGEAL JOINT, total replacement movectomy, tendon transfer or realignment -
46312	Fee: \$687.80	Benefit: 75% = \$515.85	
			NGEAL JOINT, total replacement novectomy, tendon transfer or realignment -
46315	Fee: \$917.00	Benefit: 75% = \$687.75	
			NGEAL JOINT, total replacement movectomy, tendon transfer or realignment -
46318	Fee: \$1,146.30	Benefit: 75% = \$859.75	
			ANGEAL JOINT, total replacement novectomy, tendon transfer or realignment -
46321	Fee: \$1,375.55	Benefit: 75% = \$1031.70 85% = \$1290	0.85
		REPLACEMENT ARTHROPLASTY in performed (Anaes.) (Assist.)	cluding associated tendon transfer or
46324	Fee: \$820.25	Benefit: 75% = \$615.20	
			THROPLASTY using adjacent tendon or lignment when performed (Anaes.) (Assist.)
46325	Fee: \$856.00	Benefit: 75% = \$642.00	
	INTER-PHALAN	GEAL JOINT or METACARPOPHALA	ANGEAL JOINT, arthrotomy of (Anaes.)
46327	Fee: \$206.40	Benefit: 75% = \$154.80 85% = \$175.4	15
46330	INTER-PHALAN		ANGEAL JOINT, ligamentous or capsular

T8. SUR		TIONS 14. HAND SURGERY
	repair with or w	ithout arthrotomy (Anaes.) (Assist.)
	Fee: \$351.65	Benefit: 75% = \$263.75
		ANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using or implant (Anaes.) (Assist.)
46333	Fee: \$573.05	Benefit: 75% = \$429.80
		ANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, r debridement of, not being a service associated with any procedure related to that joint)
46336	Fee: \$267.50	Benefit: 75% = \$200.65 85% = \$227.40
	EXTENSOR TI	ENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.)
46339	Fee: \$473.65	Benefit: 75% = \$355.25 85% = \$402.65
	DISTAL RADI (Anaes.) (Assist	OULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of)
46342	Fee: \$473.65	Benefit: 75% = \$355.25
		OULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous l excision of distal ulna, when performed (Anaes.) (Assist.)
46345	Fee: \$573.05	Benefit: 75% = \$429.80
	DIGIT, synoved	ctomy of flexor tendon or tendons - 1 digit (Anaes.)
46348	Fee: \$248.35	Benefit: 75% = \$186.30 85% = \$211.10
	DIGIT, synoved	ctomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.)
46351	Fee: \$370.65	Benefit: 75% = \$278.00
	DIGIT, synoved	ctomy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.)
46354	Fee: \$496.65	Benefit: 75% = \$372.50
	DIGIT, synoved	ctomy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.)
46357	Fee: \$618.95	Benefit: 75% = \$464.25
	DIGIT, synoved	ctomy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.)
46360	Fee: \$745.10	Benefit: 75% = \$558.85
		ATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS
46363	Fee: \$213.95	Benefit: 75% = \$160.50 85% = \$181.90
		S CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.)
46366	Fee: \$129.95	Benefit: 75% = \$97.50 85% = \$110.50
		S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.)
46369	Fee: \$213.95	Benefit: 75% = \$160.50 85% = \$181.90
46372		S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand

T8. SUR	GICAL OPERAT	IONS 14. HAND SURGERY
	(Anaes.) (Assist.)
	Fee: \$434.80	Benefit: 75% = \$326.10 85% = \$369.60
	DUPUYTREN'S hand (Anaes.) (A	CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 Assist.)
46375	Fee: \$515.80	Benefit: 75% = \$386.85 85% = \$438.45
		CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of Anaes.) (Assist.)
46378	Fee: \$687.80	Benefit: 75% = \$515.85
		NGEAL JOINT, joint capsule release when performed in conjunction with operation for attracture - each procedure (Anaes.) (Assist.)
46381	Fee: \$305.60	Benefit: 75% = \$229.20
		imilar local flap procedure) when performed in conjunction with operation for atracture - 1 such procedure (Anaes.) (Assist.)
46384	Fee: \$305.60	Benefit: 75% = \$229.20
		CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - nurrence in that ray (Anaes.) (Assist.)
46387	Fee: \$630.55	Benefit: 75% = \$472.95 85% = \$545.85
		CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - urrence in those rays (Anaes.) (Assist.)
46390	Fee: \$840.75	Benefit: 75% = \$630.60
		CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of on for recurrence in those rays (Anaes.) (Assist.)
46393	Fee: \$974.35	Benefit: 75% = \$730.80
		METACARPAL OF THE HAND, osteotomy or osteectomy of, and excluding services 933 or 47936 apply (Anaes.) (Assist.)
46396	Fee: \$334.85	Benefit: 75% = \$251.15 85% = \$284.65
	PHALANX OR (Assist.)	METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.)
46399	Fee: \$526.10	Benefit: 75% = \$394.60
	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtainin graft material (Anaes.) (Assist.)	
46402	Fee: \$526.10	Benefit: 75% = \$394.60
		IETACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal uding obtaining of graft material (Anaes.) (Assist.)
46405	Fee: \$642.00	Benefit: 75% = \$481.50
	TENDON, recor	nstruction of, by tendon graft (Anaes.) (Assist.)
46408	Fee: \$703.05	Benefit: 75% = \$527.30

T8. SUR	GICAL OPERAT	IONS 14. HAND SURGERY	
	FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes.) (Assist.)		
46411	Fee: \$412.65	Benefit: 75% = \$309.50	
	ARTIFICIAL TI (Assist.)	ENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.)	
46414	Fee: \$534.80	Benefit: 75% = \$401.10 85% = \$454.60	
	TENDON transf	er for restoration of hand function, each transfer (Anaes.) (Assist.)	
46417	Fee: \$496.65	Benefit: 75% = \$372.50	
	EXTENSOR TE	NDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.)	
46420	Fee: \$207.85	Benefit: 75% = \$155.90 85% = \$176.70	
	EXTENSOR TE	NDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.)	
46423	Fee: \$332.40	Benefit: 75% = \$249.30 85% = \$282.55	
	FLEXOR TEND (Anaes.) (Assist.	ON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon)	
46426	Fee: \$343.80	Benefit: 75% = \$257.85	
	FLEXOR TEND (Anaes.) (Assist.	ON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon	
46429	Fee: \$420.25	Benefit: 75% = \$315.20 85% = \$357.25	
	FLEXOR TEND	ON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)	
46432	Fee: \$458.55	Benefit: 75% = \$343.95	
	FLEXOR TEND	ON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)	
46435	Fee: \$534.90	Benefit: 75% = \$401.20	
	MALLET FING	ER, closed pin fixation of (Anaes.)	
46438	Fee: \$137.60	Benefit: 75% = \$103.20 85% = \$117.00	
	MALLET FING	ER, open repair of, including pin fixation when performed (Anaes.) (Assist.)	
46441	Fee: \$332.40	Benefit: 75% = \$249.30 85% = \$282.55	
		ER with intra articular fracture involving more than one third of base of terminal eduction (Anaes.) (Assist.)	
46442	Fee: \$285.35	Benefit: 75% = \$214.05	
	BOUTONNIER	E DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.)	
46444	Fee: \$496.65	Benefit: 75% = \$372.50	
	BOUTONNIER	E DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.)	
46447	Fee: \$618.95	Benefit: 75% = \$464.25	
		NDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.)	
46450	Fee: \$229.30	Benefit: 75% = \$172.00	

T8. SUF	RGICAL OPERA	IONS 14. HAND SURGERY	
	FLEXOR TEN	ON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.)	
46453	Fee: \$382.10	Benefit: 75% = \$286.60	
	FINGER, percu	aneous tenotomy of (Anaes.)	
46456	Fee: \$99.35	Benefit: 75% = \$74.55 85% = \$84.45	
	OPERATION f	r OSTEOMYELITIS on distal phalanx (Anaes.)	
46459	Fee: \$191.05	Benefit: 75% = \$143.30 85% = \$162.40	
	OPERATION f (Assist.)	r OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.)	
46462	Fee: \$305.60	Benefit: 75% = \$229.20 85% = \$259.80	
	AMPUTATION	of a supernumerary complete digit (Anaes.)	
46464	Fee: \$229.30	Benefit: 75% = \$172.00 85% = \$194.95	
		of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and sue cover (Anaes.)	
46465	Fee: \$229.30	Benefit: 75% = \$172.00 85% = \$194.95	
	AMPUTATION tissue cover (An	of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46468	Fee: \$401.20	Benefit: 75% = \$300.90	
	AMPUTATION tissue cover (An	of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46471	Fee: \$573.05	Benefit: 75% = \$429.80 85% = \$488.35	
	AMPUTATION tissue cover (An	of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46474	Fee: \$745.10	Benefit: 75% = \$558.85	
	AMPUTATION tissue cover (An	of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46477	Fee: \$917.00	Benefit: 75% = \$687.75	
	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.)		
46480	Fee: \$382.10	Benefit: 75% = \$286.60 85% = \$324.80	
	REVISION of A	MPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.)	
46483	Fee: \$305.60	Benefit: 75% = \$229.20 85% = \$259.80	
		rate reconstruction of nail bed laceration using magnification, undertaken in the of a hospital (Anaes.)	
46486	Fee: \$229.30	Benefit: 75% = \$172.00	
		ondary exploration and accurate repair of nail bed deformity using magnification, e operating theatre of a hospital (Anaes.) (Assist.)	
46489	Fee: \$267.50	Benefit: 75% = \$200.65	

T8. SUF	RGICAL OPERAT	IONS	14. HAND SURGERY
		E OF DIGITS OF HAND, a boutaneous tissue (Anaes.) (flexor or extensor, correction of, involving tissues deeper (Assist.)
46492	Fee: \$366.85	Benefit: 75% = \$275.15	5
	GANGLION OF in this Group app		eing a service associated with a service to which another item
46494	Fee: \$223.45	Benefit: 75% = \$167.60	0 85% = \$189.95
		MUCOUS CYST OF DIS which item 30107 applies (STAL DIGIT, excision of, other than a service associated (Anaes.)
46495	Fee: \$206.40	Benefit: 75% = \$154.80	0 85% = \$175.45
		FLEXOR TENDON SHEA item 30107 applies (Anaes.	ATH, excision of, other than a service associated with a s.)
46498	Fee: \$223.45	Benefit: 75% = \$167.60	0 85% = \$189.95
		DORSAL WRIST JOINT, 7 applies (Anaes.) (Assist.)	, excision of, other than a service associated with a service to
46500	Fee: \$267.50	Benefit: 75% = \$200.65	5 85% = \$227.40
		VOLAR WRIST JOINT, e 7 applies (Anaes.) (Assist.)	excision of, other than a service associated with a service to
46501	Fee: \$334.45	Benefit: 75% = \$250.85	5 85% = \$284.30
		ANGLION OF DORSAL which item 30107 applies (WRIST JOINT, excision of, other than a service associated (Anaes.) (Assist.)
46502	Fee: \$307.80	Benefit: 75% = \$230.85	5 85% = \$261.65
		ANGLION OF VOLAR W which item 30107 applies (WRIST JOINT, excision of, other than a service associated (Anaes.) (Assist.)
46503	Fee: \$384.45	Benefit: 75% = \$288.35	5 85% = \$326.80
	NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.)		pulp innervation (Anaes.) (Assist.)
46504	Fee: \$1,123.25	Benefit: 75% = \$842.45	5 85% = \$1038.55
			of, on vascular pedicle, complete procedure (Anaes.) (Assist.)
46507	Fee: \$1,306.80	Benefit: 75% = \$980.10	0
			enlarged elements - each digit (Anaes.) (Assist.)
46510	Fee: \$356.60	Benefit: 75% = \$267.45	5
			3, removal of, not being a service to which item 46516 applies
46513	Fee: \$57.40	Benefit: 75% = \$43.05	85% = \$48.80
	DIGITAL NAIL	OF FINGER OR THUMB	B, removal of, in the operating theatre of a hospital (Anaes.)
46516	Fee: \$114.65	Benefit: 75% = \$86.00	
	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes.)		
46519			

T8. SUF	GICAL OPERAT	ONS	14. HAND SURGERY	
	Fee: \$143.50	Benefit: 75% = \$107.65 85% = \$	122.00	
	FLEXOR TEND (Anaes.) (Assist.)		MB, open operation and drainage for infection	
46522	Fee: \$427.95	Benefit: 75% = \$321.00		
			ND, incision for, when performed in an operating her item in this Group applies (excluding after-	
46525	Fee: \$57.40	Benefit: 75% = \$43.05 85% = \$4	8.80	
		AIL OF FINGER OR THUMB, wed and portion of the nail bed (Anaes.)	ge resection for, including removal of segment of	
46528	Fee: \$172.20	Benefit: 75% = \$129.15 85% = \$	146.40	
		AIL OF FINGER OR THUMB, parti ision of nail bed (Anaes.)	al resection of nail, including phenolisation but	
46531	Fee: \$86.50	Benefit: 75% = \$64.90 85% = \$7	3.55	
	NAIL PLATE IN	JURY OR DEFORMITY, radical ex	cision of nail germinal matrix (Anaes.)	
46534	Fee: \$239.25	Benefit: 75% = \$179.45 85% = \$	203.40	
T8. SUF	GICAL OPERAT	ONS	15. ORTHOPAEDIO	
	Group T8. Surgi	cal Operations		
		Subgroup 15.	Orthopaedic	
		TREATMENT OF D	DISLOCATIONS	
	MANDIBLE, tre	atment of dislocation of, by closed re	duction (Anaes.)	
47000	Fee: \$71.80	Benefit: 75% = \$53.85 85% = \$6	1.05	
	CLAVICLE, trea	tment of dislocation of, by closed rec	luction (Anaes.)	
47003	Fee: \$86.15	Benefit: 75% = \$64.65 85% = \$7	3.25	
	CLAVICLE, trea	tment of dislocation of, by open redu	ction (Anaes.)	
47006	Fee: \$172.95	Benefit: 75% = \$129.75 85% = \$	147.05	
	SHOULDER, tre item 47012 appli		eneral anaesthesia, not being a service to which	
47009	Fee: \$172.20	Benefit: 75% = \$129.15 85% = \$	146.40	
	SHOULDER, tre (Assist.)	atment of dislocation of, requiring ge	eneral anaesthesia, open reduction (Anaes.)	
47012	Fee: \$344.25	Benefit: 75% = \$258.20		
	SHOULDER, treatment of dislocation of, not requiring general anaesthesia			
47015	Fee: \$86.15	Benefit: 75% = \$64.65 85% = \$7	3.25	
47018		ent of dislocation of, by closed reduct		

GICAL OPERAT	IONS 15. ORTHOPAEDIC
Fee: \$200.75	Benefit: 75% = \$150.60 85% = \$170.65
ELBOW, treatme	ent of dislocation of, by open reduction (Anaes.) (Assist.)
Fee: \$267.80	Benefit: 75% = \$200.85
	JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not ssociated with fracture or dislocation in the same region (Anaes.)
Fee: \$200.75	Benefit: 75% = \$150.60 85% = \$170.65
	JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not ssociated with fracture or dislocation in the same region (Anaes.) (Assist.)
Fee: \$267.80	Benefit: 75% = \$200.85
	RPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of v closed reduction (Anaes.)
Fee: \$200.75	Benefit: 75% = \$150.60 85% = \$170.65
	RPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of open reduction (Anaes.) (Assist.)
Fee: \$267.80	Benefit: 75% = \$200.85 85% = \$227.65
INTERPHALAN	IGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)
Fee: \$86.15	Benefit: 75% = \$64.65 85% = \$73.25
INTERPHALAN	IGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)
Fee: \$114.65	Benefit: 75% = \$86.00 85% = \$97.50
METACARPOP	HALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)
Fee: \$114.65	Benefit: 75% = \$86.00 85% = \$97.50
	HALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)
Foo. \$152.15	Benefit: 75% = \$114.90 85% = \$130.20
	f dislocation of, by closed reduction (Anaes.)
	Benefit: $75\% = 247.50 $85\% = 280.50 f dislocation of, by open reduction (Anaes.) (Assist.)
	Benefit: 75% = \$329.95
KNEE, treatmen	t of dislocation of, by closed reduction (Anaes.) (Assist.)
Fee: \$330.00	Benefit: 75% = \$247.50 85% = \$280.50
PATELLA, treat	ment of dislocation of, by closed reduction (Anaes.)
Fee: \$129.05	Benefit: 75% = \$96.80 85% = \$109.70
PATELLA, treat	ment of dislocation of, by open reduction (Anaes.)
Fee: \$172.20	Benefit: 75% = \$129.15 85% = \$146.40
ANKLE or TAR	SUS, treatment of dislocation of, by closed reduction (Anaes.)
Fee: \$258.25	Benefit: 75% = \$193.70 85% = \$219.55
	ELBOW, treatment Fee: \$267.80 RADIOULNAR being a service as Fee: \$200.75 RADIOULNAR being a service as Fee: \$267.80 CARPUS, or CA dislocation of, by Fee: \$200.75 CARPUS, or CA dislocation of, by Fee: \$267.80 CARPUS, or CA dislocation of, by Fee: \$267.80 INTERPHALAN Fee: \$86.15 INTERPHALAN Fee: \$114.65 METACARPOPI Fee: \$100.00 HIP, treatment of Fee: \$330.00 HIP, treatment of Fee: \$129.05 PATELLA, treatment Fee

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	ANKLE or TARSUS, treatment of dislocation of, by open reduction (An	aes.) (Assist.)
47066	Fee: \$344.25 Benefit: 75% = \$258.20	
	TOE, treatment of dislocation of, by closed reduction (Anaes.)	
47069	Fee: \$71.80 Benefit: 75% = \$53.85 85% = \$61.05	
	TOE, treatment of dislocation of, by open reduction (Anaes.)	
47072	Fee: \$95.50 Benefit: 75% = \$71.65 85% = \$81.20	
	TREATMENT OF FRACTURES	
	Phalanx, middle or proximal, treatment of fracture of, by closed reduction provided on the same occasion as a service described in item 47304, 4730 47319 (Anaes.)	
47301	(See para TN.8.124 of explanatory notes to this Category) Fee: \$88.20 Benefit: 75% = \$66.15 85% = \$75.00	
	Metacarpal, treatment of fracture of, by closed reduction, requiring anaes same occasion as a service described in item 47301, 47307, 47310, 47312	
47304	(See para TN.8.124 of explanatory notes to this Category) Fee: \$100.50 Benefit: 75% = \$75.40	
	Phalanx or metacarpal, treatment of fracture of, by closed reduction with (Anaes.) (Assist.)	percutaneous K wire fixation
47307	(See para TN.8.124 of explanatory notes to this Category) Fee: \$203.20 Benefit: 75% = \$152.40	
	Phalanx or metacarpal, treatment of fracture of, by open reduction with fi	ixation (Anaes.) (Assist.)
47310	(See para TN.8.124 of explanatory notes to this Category) Fee: \$335.30 Benefit: 75% = \$251.50	
	Phalanx or metacarpal, treatment of intra articular fracture of, by closed r wire fixation (Anaes.) (Assist.)	reduction with percutaneous K
47313	(See para TN.8.124 of explanatory notes to this Category) Fee: \$325.10 Benefit: 75% = \$243.85	
	Phalanx or metacarpal, treatment of intra articular fracture of, by open reprovided on the same occasion as a service to which item 47319 applies (
47316	(See para TN.8.124 of explanatory notes to this Category) Fee: \$645.15 Benefit: 75% = \$483.90	
	Middle phalanx, proximal end, treatment of intra articular fracture of, by not provided on the same occasion as a service to which item 47316 appl	
47319	(See para TN.8.124 of explanatory notes to this Category) Fee: \$660.40 Benefit: 75% = \$495.30	
	CARPUS (excluding scaphoid), treatment of fracture of, not being a serv (Anaes.)	ice to which item 47351 applies
47348	Fee: \$95.50 Benefit: 75% = \$71.65 85% = \$81.20	
	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction	on (Anaes.)
47351	Fee: \$239.25 Benefit: 75% = \$179.45 85% = \$203.40	

T8. SUF	GICAL OPERATIONS	15. ORTHOPAEDIC
	CARPAL SCAPHOID, treatment of fracture of, not being a serv (Anaes.)	vice to which item 47357 applies
47354	Fee: \$172.20 Benefit: 75% = \$129.15 85% = \$146.40	
	CARPAL SCAPHOID, treatment of fracture of, by open reducti	on (Anaes.) (Assist.)
47357	Fee: \$382.55 Benefit: 75% = \$286.95 85% = \$325.20	
	Radius or ulna, or radius and ulna, distal end of, treatment of fra than a service associated with a service to which item 47362, 47	•
47361	(See para TN.8.124 of explanatory notes to this Category) Fee: \$133.95 Benefit: 75% = \$100.50 85% = \$113.90	
	Radius or ulna, or radius and ulna, distal end of, treatment of fra general or major regional anaesthesia, but excluding local infiltr with a service to which item 47361, 47364, 47367, 47370 or 473	ation, other than a service associated
47362	(See para TN.8.124 of explanatory notes to this Category) Fee: \$200.75 Benefit: 75% = \$150.60 85% = \$170.65	
	Radius or ulna, distal end of, not involving joint surface, treatme fixation, other than a service associated with a service to which (Assist.)	
47364	(See para TN.8.124 of explanatory notes to this Category) Fee: \$284.50 Benefit: 75% = \$213.40	
	Radius, distal end of, treatment of fracture of, by closed reduction a service associated with a service to which item 47361 or 47362	
47367	(See para TN.8.124 of explanatory notes to this Category) Fee: \$227.20 Benefit: 75% = \$170.40	
	Radius, distal end of, treatment of intra articular fracture of, by a service associated with a service to which item 47361 or 47362	
47370	(See para TN.8.124 of explanatory notes to this Category) Fee: \$412.50 Benefit: 75% = \$309.40	
	Ulna, distal end of, treatment of intra articular fracture of, by op service associated with a service to which item 47361 or 47362	
47373	(See para TN.8.124 of explanatory notes to this Category) Fee: \$294.65 Benefit: 75% = \$221.00	
	RADIUS OR ULNA, shaft of, treatment of fracture of, by cast in which item 47381, 47384, 47385 or 47386 applies (Anaes.)	mmobilisation, not being a service to
47378	Fee: \$172.20 Benefit: 75% = \$129.15 85% = \$146.40	
	RADIUS OR ULNA, shaft of, treatment of fracture of, by closed theatre of a hospital (Anaes.)	d reduction undertaken in the operating
47381	Fee: \$258.25 Benefit: 75% = \$193.70	
	RADIUS OR ULNA, shaft of, treatment of fracture of, by open	reduction (Anaes.) (Assist.)
47384	Fee: \$344.25 Benefit: 75% = \$258.20	
47385	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunulnar joint or proximal radio-humeral joint (Galeazzi or Monteg	

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	undertaken in the	e operating theatre of a hospital (Anaes.) (Assist.)
	Fee: \$296.40	Benefit: 75% = \$222.30
		NA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio- oximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal (Assist.)
47386	Fee: \$478.25	Benefit: 75% = \$358.70
		JLNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to 0 or 47393 applies (Anaes.) (Assist.)
47387	Fee: \$277.30	Benefit: 75% = \$208.00 85% = \$235.75
		JLNA, shafts of, treatment of fracture of, by closed reduction undertaken in the of a hospital (Anaes.)
47390	Fee: \$416.10	Benefit: 75% = \$312.10
	RADIUS AND	JLNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47393	Fee: \$554.75	Benefit: 75% = \$416.10
	OLECRANON,	treatment of fracture of, not being a service to which item 47399 applies (Anaes.)
47396	Fee: \$191.20	Benefit: 75% = \$143.40 85% = \$162.55
	OLECRANON,	treatment of fracture of, by open reduction (Anaes.) (Assist.)
47399	Fee: \$382.55	Benefit: 75% = \$286.95
	OLECRANON, tendon (Anaes.)	treatment of fracture of, involving excision of olecranon fragment and reimplantation of
47402	Fee: \$286.85	Benefit: 75% = \$215.15 85% = \$243.85
	RADIUS, treatm	ent of fracture of head or neck of, closed reduction of (Anaes.)
47405	Fee: \$191.20	Benefit: 75% = \$143.40 85% = \$162.55
		ent of fracture of head or neck of, open reduction of, including internal fixation and erformed (Anaes.) (Assist.)
47408	Fee: \$382.55	Benefit: 75% = \$286.95
	HUMERUS, trea (Anaes.)	atment of fracture of tuberosity of, not being a service to which item 47417 applies
47411	Fee: \$114.65	Benefit: 75% = \$86.00 85% = \$97.50
	HUMERUS, trea	atment of fracture of tuberosity of, by open reduction (Anaes.)
47414	Fee: \$229.60	Benefit: 75% = \$172.20 85% = \$195.20
	HUMERUS, trea reduction (Anaes	atment of fracture of tuberosity of, and associated dislocation of shoulder, by closed s.) (Assist.)
47417	Fee: \$267.80	Benefit: 75% = \$200.85 85% = \$227.65
	HUMERUS, trea reduction (Anaes	atment of fracture of tuberosity of, and associated dislocation of shoulder, by open s.) (Assist.)
47420	Fee: \$526.10	Benefit: 75% = \$394.60

10. 301	RGICAL OPERAT	IONS 15. ORTHOPAEDI
	HUMERUS, pro 47432 applies (A	ximal, treatment of fracture of, not being a service to which item 47426, 47429 or naes.)
47423	Fee: \$219.95	Benefit: 75% = \$165.00 85% = \$187.00
	HUMERUS, pro of a hospital (An	ximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre aes.)
47426	Fee: \$330.00	Benefit: 75% = \$247.50
	HUMERUS, pro	ximal, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47429	Fee: \$439.90	Benefit: 75% = \$329.95
	HUMERUS, pro	ximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.)
47432	Fee: \$549.95	Benefit: 75% = \$412.50
	HUMERUS, pro reduction (Anaes	ximal, treatment of fracture of, and associated dislocation of shoulder, by closed
47435	Fee: \$420.90	Benefit: 75% = \$315.70 85% = \$357.80
	HUMERUS, pro reduction (Anaes	ximal, treatment of fracture of, and associated dislocation of shoulder, by open s.) (Assist.)
47438	Fee: \$669.70	Benefit: 75% = \$502.30
	HUMERUS, pro open reduction (ximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, b Anaes.) (Assist.)
47441	Fee: \$836.95	Benefit: 75% = \$627.75
	HUMERUS, sha (Anaes.)	ft of, treatment of fracture of, not being a service to which item 47447 or 47450 applie
47444	Fee: \$229.60	Benefit: 75% = \$172.20 85% = \$195.20
	HUMERUS, sha a hospital (Anae	ft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre (5.)
47447	Fee: \$344.25	Benefit: 75% = \$258.20
	HUMERUS, sha	ft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)
47450	Fee: \$459.20	Benefit: 75% = \$344.40
	HUMERUS, sha	ft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.)
47451	Fee: \$553.50	Benefit: 75% = \$415.15
	HUMERUS, dis	al, (supracondylar or condylar), treatment of fracture of, not being a service to which 459 applies (Anaes.) (Assist.)
47453	Fee: \$267.80	Benefit: 75% = \$200.85 85% = \$227.65
	HUMERUS, dis	al (supracondylar or condylar), treatment of fracture of, by closed reduction, undertake heatre of a hospital (Anaes.)
47456	Fee: \$401.85	Benefit: 75% = \$301.40
	HUMERUS, dis	al (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	Fee: \$535.70	Benefit: 75% = \$401.80
	CLAVICLE, trea	atment of fracture of, not being a service to which item 47465 applies (Anaes.)
47462	Fee: \$114.65	Benefit: 75% = \$86.00 85% = \$97.50
	CLAVICLE, trea	atment of fracture of, by open reduction (Anaes.) (Assist.)
47465	Fee: \$229.60	Benefit: 75% = \$172.20 85% = \$195.20
+7+05		the to fracture of, not being a service to which item 47467 applies (Anaes.)
17166	Fee: \$114.65	Benefit: 75% = \$86.00 85% = \$97.50
47466		the fracture of, by open reduction (Anaes.)
47467	Fee: \$229.60	Benefit: 75% = \$172.20
	SCAPULA, neck	c or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47468	Fee: \$439.90	Benefit: 75% = \$329.95 85% = \$373.95
	RIBS (1 or more), treatment of fracture of - each attendance
47471	Fee: \$43.70	Benefit: 75% = \$32.80 85% = \$37.15
	PELVIC RING,	treatment of fracture of, not involving disruption of pelvic ring or acetabulum
47474	Fee: \$191.20	Benefit: 75% = \$143.40 85% = \$162.55
	PELVIC RING,	treatment of fracture of, with disruption of pelvic ring or acetabulum
47477	Fee: \$239.25	Benefit: 75% = \$179.45 85% = \$203.40
4/4//		treatment of fracture of, requiring traction (Anaes.) (Assist.)
47480	Fee: \$478.25	Benefit: 75% = \$358.70
	PELVIC RING,	treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.)
47483	Fee: \$573.90	Benefit: 75% = \$430.45
		treatment of fracture of, by open reduction and involving internal fixation of anterior ng diastasis of pubic symphysis (Anaes.) (Assist.)
	segment, includi	ng utastasis of public symphysis (Anaes.) (Assist.)
47486	Fee: \$956.50	Benefit: 75% = \$717.40
		treatment of fracture of, by open reduction and involving internal fixation of posterior ng sacro-iliac joint), with or without fixation of anterior segment (Anaes.) (Assist.)
47489	Fee: \$1,434.80	Benefit: 75% = \$1076.10
	ACETABULUM	I, treatment of fracture of, and associated dislocation of hip (Anaes.)
47492	Fee: \$239.25	Benefit: 75% = \$179.45 85% = \$203.40
		I, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.)
47495	Fee: \$478.25	Benefit: 75% = \$358.70 85% = \$406.55
	ACETABULUM	I, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, raction (Anaes.) (Assist.)
47498	Fee: \$717.35	Benefit: 75% = \$538.05
+/470	I CC. \$111.33	$\mathbf{Denem}, \ 1570 = \phi 550.05$

T8. SUF	GICAL OPERATIO	ONS	15. ORTHOPAEDIC
	including any oste	treatment of single column fracture of, by oper cotomy, osteectomy or capsulotomy required for s to which item 47933 or 47936 apply (Anaes.)	or exposure and subsequent repair, and
47501	Fee: \$956.50	Benefit: 75% = \$717.40	
	any osteotomy, os	treatment of T-shape fracture of, by open redu teectomy or capsulotomy required for exposure item 47933 or 47936 apply (Anaes.) (Assist.)	
47504	Fee: \$1,434.80	Benefit: 75% = \$1076.10 85% = \$1350.10	
	any osteotomy, os	treatment of transverse fracture of, by open red teectomy or capsulotomy required for exposure item 47933 or 47936 apply (Anaes.) (Assist.)	
47507	Fee: \$1,434.80	Benefit: 75% = \$1076.10	
	including any oste	treatment of double column fracture of, by operation of the process of the proces	or exposure and subsequent repair, and
47510	Fee: \$1,434.80	Benefit: 75% = \$1076.10	
		DINT DISRUPTION, treatment of, requiring in service to which items 47501 to 47510 apply (A	
47513	Fee: \$382.55	Benefit: 75% = \$286.95	
	FEMUR, treatmer	nt of fracture of, by closed reduction or traction	(Anaes.) (Assist.)
47516	Fee: \$439.90	Benefit: 75% = \$329.95 85% = \$373.95	
	FEMUR, treatmer	nt of trochanteric or subcapital fracture of, by ir	nternal fixation (Anaes.) (Assist.)
47519	Fee: \$880.05	Benefit: 75% = \$660.05	
		nt of subcapital fracture of, by hemi-arthroplast	y (Anaes.) (Assist.)
47522	Fee: \$765.30	Benefit: 75% = \$574.00	
41522		t of fracture of, for slipped capital femoral epi	physis (Anaes.) (Assist.)
47525	Fee: \$880.05	Benefit: 75% = \$660.05	
47323		t of fracture of, by internal fixation or external	fixation (Anaes) (Assist)
			nxauon (r macs.) (r ssist.)
47528	Fee: \$765.30	Benefit: 75% = \$574.00	n and arous fination (Among) (Assist)
	FEMOR, treatmen	nt of fracture of shaft, by intramedullary fixatio	in and cross fixation (Anaes.) (Assist.)
47531	Fee: \$975.60	Benefit: 75% = \$731.70	
		r region of, treatment of intra-articular (T-shape with or without internal fixation of 1 or more os	
47534	Fee: \$1,100.00	Benefit: 75% = \$825.00	
	-	r region of, treatment of fracture of, requiring in gments, not being a service associated with a se	
47537	(111000.) (1200151.)		

T8. SUF	GICAL OPERAT	ONS 15. ORTHOPAEDIC
	Fee: \$439.90	Benefit: 75% = \$329.95 85% = \$373.95
	HIP SPICA OR S	SHOULDER SPICA, application of, as an independent procedure (Anaes.)
47540	Fee: \$219.95	Benefit: 75% = \$165.00 85% = \$187.00
	TIBIA, plateau o 47549 applies (A	f, treatment of medial or lateral fracture of, not being a service to which item 47546 or naes.)
47543	Fee: \$229.60	Benefit: 75% = \$172.20 85% = \$195.20
	TIBIA, plateau o	f, treatment of medial or lateral fracture of, by closed reduction (Anaes.)
47546	Fee: \$344.25	Benefit: 75% = \$258.20 85% = \$292.65
	TIBIA, plateau o	f, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.)
47549	Fee: \$459.20	Benefit: 75% = \$344.40
		f, treatment of both medial and lateral fractures of, not being a service to which item applies (Anaes.) (Assist.)
47552	Fee: \$382.55	Benefit: 75% = \$286.95 85% = \$325.20
	TIBIA, plateau o	f, treatment of both medial and lateral fractures of, by closed reduction (Anaes.)
47555	Fee: \$573.90	Benefit: 75% = \$430.45
	TIBIA, plateau o	f, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.)
47558	Fee: \$765.30	Benefit: 75% = \$574.00
		reatment of fracture of, by cast immobilisation, not being a service to which item (570 or 47573 applies (Anaes.)
47561	Fee: \$277.30	Benefit: 75% = \$208.00 85% = \$235.75
	TIBIA, shaft of, fracture (Anaes.)	reatment of fracture of, by closed reduction, with or without treatment of fibular
47564	Fee: \$416.10	Benefit: 75% = \$312.10 85% = \$353.70
	TIBIA, shaft of,	reatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)
47565	Fee: \$723.80	Benefit: 75% = \$542.85
	TIBIA, shaft of,	reatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.)
47566	Fee: \$922.60	Benefit: 75% = \$691.95
	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)	
47567	Fee: \$482.95	Benefit: 75% = \$362.25 85% = \$410.55
	TIBIA, shaft of, (Anaes.) (Assist.	reatment of fracture of, by open reduction, with or without treatment of fibular fracture
47570	Fee: \$554.75	Benefit: 75% = \$416.10 85% = \$471.55
	TIBIA, shaft of, fibula fracture (A	reatment of intra-articular fracture of, by open reduction, with or without treatment of naes.) (Assist.)
47573	Fee: \$693.45	Benefit: 75% = \$520.10

T8. SUF	RGICAL OPERATIO	NS 15. ORTHOPAEDIC
	FIBULA, treatment	t of fracture of (Anaes.)
47576	Fee: \$114.65	Benefit: 75% = \$86.00 85% = \$97.50
	PATELLA, treatme	ent of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.)
47579	Fee: \$162.60	Benefit: 75% = \$121.95 85% = \$138.25
	PATELLA, treatme (Assist.)	ent of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.)
47582	Fee: \$334.85	Benefit: 75% = \$251.15
	PATELLA, treatme	ent of fracture of, by internal fixation (Anaes.) (Assist.)
47585	Fee: \$430.55	Benefit: 75% = \$322.95
		tment of fracture of, by internal fixation of intra-articular fractures of femoral recurs surfaces and requiring repair or reconstruction of 1 or more ligaments
47588	Fee: \$1,338.90	Benefit: 75% = \$1004.20
		tment of fracture of, by internal fixation of intra-articular fractures of femoral articular surfaces and requiring repair or reconstruction of 1 or more ligaments
47591	Fee: \$1,626.25	Benefit: 75% = \$1219.70
	ANKLE JOINT, tre	eatment of fracture of, not being a service to which item 47597 applies (Anaes.)
47594	Fee: \$219.95	Benefit: 75% = \$165.00 85% = \$187.00
	ANKLE JOINT, tre	eatment of fracture of, by closed reduction (Anaes.)
47597	Fee: \$330.00	Benefit: 75% = \$247.50 85% = \$280.50
	ANKLE JOINT, tre (Anaes.) (Assist.)	eatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis
47600	Fee: \$439.90	Benefit: 75% = \$329.95
	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.)	
47603	Fee: \$573.90	Benefit: 75% = \$430.45
		TALUS, treatment of fracture of, not being a service to which item 47609, 47612, blies, with or without dislocation (Anaes.)
47606	Fee: \$239.25	Benefit: 75% = \$179.45 85% = \$203.40
	CALCANEUM OR (Anaes.) (Assist.)	TALUS, treatment of fracture of, by closed reduction, with or without dislocation
47609	Fee: \$358.70	Benefit: 75% = \$269.05 85% = \$304.90
	CALCANEUM OR dislocation (Anaes.	R TALUS, treatment of intra-articular fracture of, by closed reduction, with or without) (Assist.)
47612	Fee: \$416.10	Benefit: 75% = \$312.10 85% = \$353.70
47615	CALCANEUM OR	TALUS, treatment of fracture of, by open reduction, with or without dislocation

T8. SUF	RGICAL OPERATIO	DNS 15. ORTHOPAEDIC
	(Anaes.) (Assist.)	
	Fee: \$478.25	Benefit: 75% = \$358.70 85% = \$406.55
	CALCANEUM O dislocation (Anaes	R TALUS, treatment of intra-articular fracture of, by open reduction, with or without s.) (Assist.)
47618	Fee: \$597.85	Benefit: 75% = \$448.40
	TARSO-METATA dislocation (Anaes	ARSAL, treatment of intra-articular fracture of, by closed reduction, with or without s.) (Assist.)
47621	Fee: \$416.10	Benefit: 75% = \$312.10 85% = \$353.70
	TARSO-METATA (Anaes.) (Assist.)	ARSAL, treatment of fracture of, by open reduction, with or without dislocation
47624	Fee: \$573.90	Benefit: 75% = \$430.45
	TARSUS (excludi	ng calcaneum or talus), treatment of fracture of (Anaes.)
47627	Fee: \$162.60	Benefit: 75% = \$121.95 85% = \$138.25
	TARSUS (excludi dislocation (Anaes	ng calcaneum or talus), treatment of fracture of, by open reduction, with or without s.) (Assist.)
47630	Fee: \$344.25	Benefit: 75% = \$258.20 85% = \$292.65
	METATARSAL,	1 of, treatment of fracture of (Anaes.)
47633	Fee: \$114.65	Benefit: 75% = \$86.00 85% = \$97.50
	METATARSAL,	1 of, treatment of fracture of, by closed reduction (Anaes.)
47636	Fee: \$172.20	Benefit: 75% = \$129.15 85% = \$146.40
	METATARSAL,	1 of, treatment of fracture of, by open reduction (Anaes.)
47639	Fee: \$229.60	Benefit: 75% = \$172.20 85% = \$195.20
	METATARSALS	, 2 of, treatment of fracture of (Anaes.)
47642	Fee: \$153.15	Benefit: 75% = \$114.90 85% = \$130.20
	METATARSALS	, 2 of, treatment of fracture of, by closed reduction (Anaes.)
47645	Fee: \$229.60	Benefit: 75% = \$172.20 85% = \$195.20
	METATARSALS	, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47648	Fee: \$305.85	Benefit: 75% = \$229.40
	METATARSALS	, 3 or more of, treatment of fracture of (Anaes.)
47651	Fee: \$239.25	Benefit: 75% = \$179.45 85% = \$203.40
		, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.)
47654	Fee: \$358.70	Benefit: 75% = \$269.05 85% = \$304.90
		, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47657	Fee: \$478.25	Benefit: 75% = \$358.70
1001	Δ UU φ τ / 0.23	Denom: 1570 - \$550.10

T8. SUF	GICAL OPERAT	ONS 15. ORTHOPAEDIC
	PHALANX OF	REAT TOE, treatment of fracture of, by closed reduction (Anaes.)
47663	Fee: \$143.50	Benefit: 75% = \$107.65 85% = \$122.00
	PHALANX OF	REAT TOE, treatment of fracture of, by open reduction (Anaes.)
47666	Fee: \$239.25	Benefit: 75% = \$179.45 85% = \$203.40
	PHALANX OF	OE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.)
47672	Fee: \$114.65	Benefit: 75% = \$86.00 85% = \$97.50
	PHALANX OF (Anaes.)	OE (other than great toe), more than 1 of, treatment of fracture of, by open reduction
47678	Fee: \$172.20	Benefit: 75% = \$129.15 85% = \$146.40
	BONE GRAFT, small quantity (narvesting of, via separate incision, in conjunction with another service - autogenous - naes.)
47726	Fee: \$143.50	Benefit: 75% = \$107.65
	BONE GRAFT, large quantity (A	narvesting of, via separate incision, in conjunction with another service - autogenous - naes.)
47729	Fee: \$239.25	Benefit: 75% = \$179.45
VASCULARISED PEDICLE BONE GRAFT, harvesting (Anaes.) (Assist.)		D PEDICLE BONE GRAFT, harvesting of, in conjunction with another service
47732	Fee: \$382.55	Benefit: 75% = \$286.95
	NASAL BONE each attendance	treatment of fracture of, not being a service to which item 47738 or 47741 applies -
47735	Fee: \$43.75	Benefit: 75% = \$32.85 85% = \$37.20
	NASAL BONE	treatment of fracture of, by reduction (Anaes.)
47738	Fee: \$239.25	Benefit: 75% = \$179.45 85% = \$203.40
	NASAL BONE	treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.)
47741	Fee: \$488.05	Benefit: 75% = \$366.05
	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	
47753	Fee: \$413.15	Benefit: 75% = \$309.90
	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	
47756	Fee: \$413.15	Benefit: 75% = \$309.90
	ZYGOMATIC other approach (ONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or anaes.)
47762	Fee: \$242.60	Benefit: 75% = \$181.95 85% = \$206.25
		ONE, treatment of fracture of, requiring surgical reduction and involving internal or at 1 site (Anaes.) (Assist.)
47765	Fee: \$398.35	Benefit: 75% = \$298.80

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
		BONE, treatment of fracture of, requiring surgical reduction and involving internal or or both at 2 sites (Anaes.) (Assist.)
47768	Fee: \$488.05	Benefit: 75% = \$366.05
		BONE, treatment of fracture of, requiring surgical reduction and involving internal or or both at 3 sites (Anaes.) (Assist.)
47771	Fee: \$560.70	Benefit: 75% = \$420.55
	MAXILLA, trea	tment of fracture of, requiring open operation (Anaes.) (Assist.)
47774	Fee: \$442.60	Benefit: 75% = \$331.95
	MANDIBLE, tre	eatment of fracture of, requiring open reduction (Anaes.) (Assist.)
47777	Fee: \$442.60	Benefit: 75% = \$331.95
	MAXILLA, trea (Anaes.) (Assist.	tment of fracture of, requiring open reduction and internal fixation not involving plate(s))
47780	Fee: \$575.40	Benefit: 75% = \$431.55
	MANDIBLE, tre plate(s) (Anaes.)	eatment of fracture of, requiring open reduction and internal fixation not involving (Assist.)
47783	Fee: \$575.40	Benefit: 75% = \$431.55 85% = \$490.70
	MAXILLA, trea (Anaes.) (Assist.	tment of fracture of, requiring open reduction and internal fixation involving plate(s)
47786	Fee: \$730.25	Benefit: 75% = \$547.70
	MANDIBLE, tre (Anaes.) (Assist.	eatment of fracture of, requiring open reduction and internal fixation involving plate(s)
47789	Fee: \$730.25	Benefit: 75% = \$547.70
		GENERAL
	BONE CYST, ir	jection into or aspiration of (Anaes.)
47900	Fee: \$172.20	Benefit: 75% = \$129.15 85% = \$146.40
	EPICONDYLIT	IS, open operation for (Anaes.)
47903	Fee: \$239.25	Benefit: 75% = \$179.45 85% = \$203.40
	DIGITAL NAIL	OF TOE, removal of, not being a service to which item 47906 applies (Anaes.)
47904	Fee: \$57.40	Benefit: 75% = \$43.05 85% = \$48.80
	DIGITAL NAIL	OF TOE, removal of, in the operating theatre of a hospital (Anaes.)
47906	Fee: \$114.65	Benefit: 75% = \$86.00
		NFECTION, PARONYCHIA of FOOT, incision for, not being a service to which his Group applies (excluding aftercare) (Anaes.)
47912	(See para TN.8.4 c Fee: \$57.40	of explanatory notes to this Category) Benefit: $75\% = 43.05 $85\% = 48.80
47915	INGROWING N	AIL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and

T8. SUF	GICAL OPERAT	ONS 15. ORTHOPAEDIC		
	portion of the na	l bed (Anaes.)		
	Fee: \$172.20	Benefit: 75% = \$129.15 85% = \$146.40		
		AIL OF TOE, partial resection of nail, with destruction of nail matrix by phenolisation, ser, sodium hydroxide or acid but not including excision of nail bed (Anaes.)		
47916	Fee: \$86.50	Benefit: 75% = \$64.90 85% = \$73.55		
	INGROWING 7	OENAIL, radical excision of nailbed (Anaes.)		
47918	Fee: \$239.25	Benefit: 75% = \$179.45 85% = \$203.40		
	BONE GROWT	H STIMULATOR, insertion of (Anaes.) (Assist.)		
47920	Fee: \$386.90	Benefit: 75% = \$290.20		
	ORTHOPAEDI	PIN OR WIRE, insertion of, as an independent procedure (Anaes.)		
47921	Fee: \$114.65	Benefit: 75% = \$86.00 85% = \$97.50		
		PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, ing incision and suture, not being a service to which item 47927 or 47930 applies - per		
47924	Fee: \$38.25	Benefit: 75% = \$28.70 85% = \$32.55		
	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital - per bone (Anaes.)			
47927	Fee: \$143.50	Benefit: 75% = \$107.65		
	were inserted fo	R NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which internal fixation purposes, <u>removal of</u> , not being a service associated with a service to 4 or 47927 applies - per bone (Anaes.) (Assist.)		
47930	Fee: \$267.80	Benefit: 75% = \$200.85		
		OSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision of, or f bunion and any associated bursa, not being a service associated with a service for (Anaes.)		
47933	(See para TN.8.11 Fee: \$210.30	c of explanatory notes to this Category) Benefit: 75% = \$157.75 85% = \$178.80		
	LARGE EXOST (Assist.)	OSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Anaes.)		
47936	(See para TN.8.11 Fee: \$258.25	e of explanatory notes to this Category) Benefit: 75% = \$193.70		
	EXTERNAL FI	ATION, removal of, in the operating theatre of a hospital (Anaes.)		
47948	Fee: \$162.60	Benefit: 75% = \$121.95		
	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.)			
47951	Fee: \$191.20	Benefit: 75% = \$143.40 85% = \$162.55		
	TENDON, repa	of, as an independent procedure (Anaes.) (Assist.)		
47954	Fee: \$382.55	Benefit: 75% = \$286.95 85% = \$325.20		

T8. SUR	GICAL OPERAT	TIONS 15. ORTHOPAEDIC		
	TENDON, large	e, lengthening of, as an independent procedure (Anaes.) (Assist.)		
47957	Fee: \$286.85	Benefit: 75% = \$215.15		
	TENOTOMY, S (Anaes.)	UBCUTANEOUS, not being a service to which another item in this Group applies		
47960	Fee: \$133.95	Benefit: 75% = \$100.50 85% = \$113.90		
	TENOTOMY, C Group applies (A	DPEN, with or without tenoplasty, not being a service to which another item in this Anaes.)		
47963	Fee: \$219.95	Benefit: 75% = \$165.00 85% = \$187.00		
	TENDON OR L	IGAMENT, TRANSFER, as an independent procedure (Anaes.) (Assist.)		
47966	Fee: \$439.90	Benefit: 75% = \$329.95		
	TENOSYNOVE (Assist.)	ECTOMY, not being a service to which another item in this Group applies (Anaes.)		
47969	Fee: \$267.80	Benefit: 75% = \$200.85		
	TENDON SHEA Group applies (A	ATH, open operation for teno-vaginitis, not being a service to which another item in this Anaes.)		
47972	Fee: \$213.95	Benefit: 75% = \$160.50		
	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.)			
47975	Fee: \$375.05	Benefit: 75% = \$281.30		
		CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring cle and deep tissue (Anaes.)		
47978	Fee: \$227.80	Benefit: 75% = \$170.85		
		LF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, ice to which another item applies (Anaes.)		
47981	Fee: \$152.95	Benefit: 75% = \$114.75 85% = \$130.05		
	FORAGE (Drill	decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.)		
47982	Fee: \$370.75	Benefit: 75% = \$278.10		
	BONE GRAFTS			
	FEMUR, bone g	raft to (Anaes.) (Assist.)		
48200	Fee: \$765.30	Benefit: 75% = \$574.00		
	FEMUR, bone g	raft to, with internal fixation (Anaes.) (Assist.)		
48203	Fee: \$927.85	Benefit: 75% = \$695.90		
	TIBIA, bone gra	ft to (Anaes.) (Assist.)		
48206	Fee: \$574.50	Benefit: 75% = \$430.90		
	TIBIA, bone gra	ft to, with internal fixation (Anaes.) (Assist.)		
48209	Fee: \$736.55	Benefit: 75% = \$552.45		

T8. SUF		TIONS 15. ORTHOPAEDIC		
	HUMERUS, bo	ne graft to (Anaes.) (Assist.)		
48212	Fee: \$574.50	Benefit: 75% = \$430.90		
	HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.)			
48215	Fee: \$736.55	Benefit: 75% = \$552.45		
	RADIUS AND	ULNA, bone graft to (Anaes.) (Assist.)		
48218	Fee: \$574.50	Benefit: 75% = \$430.90		
	RADIUS AND	ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)		
48221	Fee: \$765.30	Benefit: 75% = \$574.00		
	RADIUS OR U	LNA, bone graft to (Anaes.) (Assist.)		
48224	Fee: \$382.55	Benefit: 75% = \$286.95		
	RADIUS OR U	LNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)		
48227	Fee: \$497.40	Benefit: 75% = \$373.05		
	SCAPHOID, bo	one graft to, for non-union (Anaes.) (Assist.)		
48230	Fee: \$430.55	Benefit: 75% = \$322.95		
	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.)			
48233	Fee: \$621.70	Benefit: 75% = \$466.30		
	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes. (Assist.)			
48236	Fee: \$813.00	Benefit: 75% = \$609.75		
	BONE GRAFT	, not being a service to which another item in this Group applies (Anaes.) (Assist.)		
48239	Fee: \$449.55	Benefit: 75% = \$337.20		
	BONE GRAFT, with internal fixation, not being a service to which another item in this Group ap (Anaes.) (Assist.)			
48242	Fee: \$621.70	Benefit: 75% = \$466.30		
		OSTEOTOMY AND OSTEECTOMY		
	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or of, excluding services to which item 49848 or 49851 applies, any of items 49848, 49851, 479 47936 apply (Anaes.) (Assist.)			
48400	Fee: \$334.85	Benefit: 75% = \$251.15		
	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)			
48403	Fee: \$526.10	Benefit: 75% = \$394.60		
		IUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR atomy or osteectomy of, excluding services to which items 47933 or 47936 apply apply apply apply (a)		
48406	Fee: \$334.85	Benefit: 75% = \$251.15		

T8. SUR	GICAL OPERAT	ONS 15. ORTHOPAEDIC		
	CARPUS, osteor	US, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR omy or osteectomy of, with internal fixation, and excluding services to which items pply (Anaes.) (Assist.)		
48409	Fee: \$526.10	Benefit: 75% = \$394.60		
	HUMERUS, ost (Anaes.) (Assist.	otomy or osteectomy of, excluding services to which items 47933 or 47936 apply		
48412	Fee: \$640.75	Benefit: 75% = \$480.60		
		otomy or osteectomy of, with internal fixation, and excluding services to which items pply (Anaes.) (Assist.)		
48415	Fee: \$813.00	Benefit: 75% = \$609.75		
	TIBIA, osteotom (Assist.)	y or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.)		
48418	Fee: \$640.75	Benefit: 75% = \$480.60		
	TIBIA, osteotom or 47936 apply (y or osteectomy of, with internal fixation, and excluding services to which items 47933 Anaes.) (Assist.)		
48421	Fee: \$813.00	Benefit: 75% = \$609.75		
	Femur or pelvis, osteotomy or osteectomy of, other than a service associated with surgery for femoroacetabular impingement, or to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)			
48424	(See para TN.8.12 Fee: \$765.30	of explanatory notes to this Category) Benefit: 75% = \$574.00		
		VIS, osteotomy or osteectomy of, with internal fixation, and excluding services to 3 or 47936 apply (Anaes.) (Assist.)		
48427	Fee: \$927.85	Benefit: 75% = \$695.90		
		EPIPHYSEODESIS		
	FEMUR, epiphysiodesis of (Anaes.) (Assist.)			
48500	Fee: \$334.85	Benefit: 75% = \$251.15		
	TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)			
48503	Fee: \$334.85	Benefit: 75% = \$251.15		
		AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)		
48506	Fee: \$497.40	Benefit: 75% = \$373.05		
10500		IS, staple arrest of hemiepiphysis (Anaes.)		
40,500				
48509	Fee: \$239.25	Benefit: 75% = \$179.45		
	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.)			
48512	Fee: \$908.70	Benefit: 75% = \$681.55		
	arror =	SHOULDER		
48900	SHOULDER, ex (Anaes.) (Assist.	cision of coraco-acromial ligament or removal of calcium deposit from cuff or both		

T8. SUF	RGICAL OPERAT	ONS 15. ORTHOPAED
	Fee: \$286.85	Benefit: 75% = \$215.15 85% = \$243.85
		compression of subacromial space by acromioplasty, excision of coraco-acromial al clavicle, or any combination (Anaes.) (Assist.)
48903	Fee: \$573.90	Benefit: 75% = \$430.45
		air of rotator cuff, including excision of coraco-acromial ligament or removal of om cuff, or both - not being a service associated with a service to which item 48900 Assist.)
48906	Fee: \$573.90	Benefit: 75% = \$430.45
	excision of corac	air of rotator cuff, including decompression of subacromial space by acromioplasty, p-acromial ligament and distal clavicle, or any combination, not being a service service to which item 48903 applies (Anaes.) (Assist.)
48909	Fee: \$765.30	Benefit: 75% = \$574.00
	SHOULDER, art	nrotomy of (Anaes.) (Assist.)
48912	Fee: \$334.85	Benefit: 75% = \$251.15 85% = \$284.65
	SHOULDER, he	ni-arthroplasty of (Anaes.) (Assist.)
48915	Fee: \$765.30	Benefit: 75% = \$574.00
	SHOULDER, tot (Assist.)	al replacement arthroplasty of, including any associated rotator cuff repair (Anaes.)
48918	Fee: \$1,530.55	Benefit: 75% = \$1147.95
	SHOULDER, tot	al replacement arthroplasty, revision of (Anaes.) (Assist.)
48921	Fee: \$1,578.25	Benefit: 75% = \$1183.70
	SHOULDER, tot both (Anaes.) (A	al replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or sist.)
48924	Fee: \$1,817.45	Benefit: 75% = \$1363.10
	SHOULDER pro	sthesis, removal of (Anaes.) (Assist.)
48927	Fee: \$372.90	Benefit: 75% = \$279.70
	SHOULDER, sta	bilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.)
48930	Fee: \$765.30	Benefit: 75% = \$574.00
	SHOULDER, sta	pilisation procedure for multi-directional instability, including anterior or posterior (o performed (Anaes.) (Assist.)
48933	Fee: \$1,004.35	Benefit: 75% = \$753.30
		ovectomy of, as an independent procedure (Anaes.) (Assist.)
48936	Fee: \$765.30	Benefit: 75% = \$574.00
		prodesis of, with synovectomy if performed (Anaes.) (Assist.)
	,	· · · · · / / /
48939	Fee: \$1,100.00	Benefit: 75% = \$825.00

18. 304	RGICAL OPERATI	ONS 15. ORTHOPAEDIC			
	grafting or intern	al fixation (Anaes.) (Assist.)			
	Fee: \$1,434.80	Benefit: 75% = \$1076.10			
		agnostic arthroscopy of (including biopsy) - not being a service associated with any c procedure of the shoulder region (Anaes.) (Assist.)			
48945	Fee: \$277.30	Benefit: 75% = \$208.00			
	decompression of	hroscopic surgery of, involving any 1 or more of: removal of loose bodies; f calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - e associated with any other arthroscopic procedure of the shoulder region (Anaes.)			
48948	Fee: \$621.70	Benefit: 75% = \$466.30			
		hroscopic division of coraco-acromial ligament including acromioplasty - not being a d with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)			
48951	Fee: \$908.70	Benefit: 75% = \$681.55			
		hroscopic total synovectomy of, including release of contracture when performed - not ssociated with any other arthroscopic procedure of the shoulder region (Anaes.)			
48954	Fee: \$956.50	Benefit: 75% = \$717.40			
	SHOULDER, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)				
48957	Fee: \$1,100.00	Benefit: 75% = \$825.00			
	assisted or mini o	construction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic pen means; arthroscopic acromioplasty; or resection of acromioclavicular joint by n when performed - not being a service associated with any other procedure of the Anaes.) (Assist.)			
48960	Fee: \$956.50	Benefit: 75% = \$717.40			
		ELBOW			
	ELBOW, arthroto (Anaes.) (Assist.)	bmy of, involving 1 or more of lavage, removal of loose body or division of contracture			
49100	Fee: \$334.85	Benefit: 75% = \$251.15			
	ELBOW, ligamentous stabilisation of (Anaes.) (Assist.)				
49103	Fee: \$717.35	Benefit: 75% = \$538.05			
	ELBOW, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)				
49106	Fee: \$956.50	Benefit: 75% = \$717.40 85% = \$871.80			
	ELBOW, total sy	ELBOW, total synovectomy of (Anaes.) (Assist.)			
49109	Fee: \$717.35	Benefit: 75% = \$538.05			
	ELBOW, silastic	or other replacement of radial head (Anaes.) (Assist.)			

T8. SUF		ONS	15. ORTHOPAEDIC	
	ELBOW, total joint replacement of (Anaes.) (Assist.)			
49115	Fee: \$1,147.70	Benefit: 75% = \$860.80		
	ELBOW, total rep (Assist.)	placement arthroplasty of, revision procedure, including re	emoval of prosthesis (Anaes.)	
49116	Fee: \$1,515.00	Benefit: 75% = \$1136.25		
		placement arthroplasty of, revision procedure, requiring be esis (Anaes.) (Assist.)	one grafting, including	
49117	Fee: \$1,818.00	Benefit: 75% = \$1363.50		
		tic arthroscopy of, including biopsy and lavage, not being procedure of the elbow (Anaes.) (Assist.)	a service associated with any	
49118	Fee: \$277.30	Benefit: 75% = \$208.00		
	ELBOW, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.)			
49121	Fee: \$621.70	Benefit: 75% = \$466.30		
		WRIST		
	WRIST, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation of the radiocarpal joint (Anaes.) (Assist.)			
49200	(See para TN.8.116 Fee: \$832.05	of explanatory notes to this Category) Benefit: 75% = \$624.05		
	WRIST, limited a bone graft (Anaes	rthrodesis of the intercarpal joint, with synovectomy if pe .) (Assist.)	rformed, with or without	
49203	(See para TN.8.116 Fee: \$621.70	of explanatory notes to this Category) Benefit: 75% = \$466.30		
	WRIST, proximal	carpectomy of, including styloidectomy when performed	l (Anaes.) (Assist.)	
49206	(See para TN.8.116 Fee: \$573.90	of explanatory notes to this Category) Benefit: 75% = \$430.45		
	WRIST, total repl	acement arthroplasty of (Anaes.) (Assist.)		
49209	(See para TN.8.116 Fee: \$765.30	of explanatory notes to this Category) Benefit: 75% = \$574.00		
	WRIST, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.)			
49210	Fee: \$1,010.20	Benefit: 75% = \$757.65		
	WRIST, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.)			
49211	Fee: \$1,212.25	Benefit: 75% = \$909.20		
	WRIST, arthrotor	ny of (Anaes.)		
	(See para TN.8.116	of explanatory notes to this Category)		
49212	Fee: \$239.25	Benefit: 75% = \$179.45		

T8. SUF	GICAL OPERATIO	NS	15. ORTHOPAEDIC
		ction of, including repair of single or my (Anaes.) (Assist.)	multiple ligaments or capsules, including
49215	(See para TN.8.116 c Fee: \$660.10	of explanatory notes to this Category) Benefit: 75% = \$495.10	
			al or midcarpal joints, or both (including biopsy) opic procedure of the wrist joint (Anaes.)
49218	(See para TN.8.116 c Fee: \$277.30	f explanatory notes to this Category) Benefit: 75% = \$208.00	
	release of adhesion		ore of: drilling of defect; removal of loose body; nt of one area - not being a service associated (Anaes.) (Assist.)
49221	(See para TN.8.116 c Fee: \$621.70	of explanatory notes to this Category) Benefit: 75% = \$466.30	
		synovectomy, not being a service as	t areas; or osteoplasty including excision of the ssociated with any other arthroscopic procedure of
49224	(See para TN.8.116 c Fee: \$717.35	f explanatory notes to this Category) Benefit: 75% = \$538.05	
			nt or stabilisation procedure for ligamentous er arthroscopic procedure of the wrist joint
49227	(See para TN.8.116 c Fee: \$717.35	of explanatory notes to this Category) Benefit: 75% = \$538.05	
		HIP	
	SACROILIAC JOI	NT arthrodesis of (Anaes.) (Assist.)
49300	Fee: \$529.60	Benefit: 75% = \$397.20	
		, including lavage, drainage or biops gery for femoroacetabular impingen	y when performed, other than a service nent (H) (Anaes.) (Assist.)
49303	(See para TN.8.127 c Fee: \$554.75	of explanatory notes to this Category) Benefit: 75% = \$416.10	
	HIP arthrodesis of	, with synovectomy if performed (A	naes.) (Assist.)
49306	Fee: \$1,100.00	Benefit: 75% = \$825.00	
	HIP, arthrectomy o (non cement)) (An		removal of prosthesis (Austin Moore or similar
49309	Fee: \$765.30	Benefit: 75% = \$574.00	
	HIP, arthrectomy or similar) (Anaes.)		removal of prosthesis (cemented, porous coated
49312	Fee: \$956.50	Benefit: 75% = \$717.40	
		f, unipolar or bipolar (Anaes.) (Assi	st.)
49315	Fee: \$860.90	Benefit: 75% = \$645.70	
17515	L CC , \$000.70	$- \psi (\tau_{3.10}) = \psi (\tau_{3.10})$	

T8. SUF	RGICAL OPERATIO	NS 15. ORTHOPAEDIC		
	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.) (Assist.)			
49318	Fee: \$1,338.90	Benefit: 75% = \$1004.20		
	HIP, total replacen (Anaes.) (Assist.)	nent arthroplasty of, including associated minor grafting, if performed - bilateral		
49319	Fee: \$2,352.35	Benefit: 75% = \$1764.30		
	HIP, total replacen (Anaes.) (Assist.)	ent arthroplasty of, including major bone grafting, including obtaining of graft		
49321	Fee: \$1,626.25	Benefit: 75% = \$1219.70		
	HIP, total replacen (Assist.)	nent arthroplasty of, revision procedure including removal of prosthesis (Anaes.)		
49324	Fee: \$1,913.10	Benefit: 75% = \$1434.85		
		nent arthroplasty of, revision procedure requiring bone grafting to acetabulum, g of graft (Anaes.) (Assist.)		
49327	Fee: \$2,200.00	Benefit: 75% = \$1650.00		
	HIP, total replacen obtaining of graft (nent arthroplasty of, revision procedure requiring bone grafting to femur, including Anaes.) (Assist.)		
49330	Fee: \$2,200.00	Benefit: 75% = \$1650.00		
		nent arthroplasty of, revision procedure requiring bone grafting to both acetabulum ng obtaining of graft (Anaes.) (Assist.)		
49333	Fee: \$2,487.00	Benefit: 75% = \$1865.25		
	HIP, treatment of a fracture of the femur where revision total hip replacement is required as p treatment of the fracture (not including intra-operative fracture), being a service associated we to which items 49324 to 49333 apply (Anaes.) (Assist.)			
49336	Fee: \$363.40	Benefit: 75% = \$272.55		
	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater that cm in length (Anaes.) (Assist.)			
49339	Fee: \$2,821.75	Benefit: 75% = \$2116.35		
	HIP, revision total	replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.)		
49342	Fee: \$2,821.75	Benefit: 75% = \$2116.35		
	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulu (Anaes.) (Assist.)			
49345	Fee: \$3,347.80	Benefit: 75% = \$2510.85		
	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.)			
49346	Fee: \$860.90	Benefit: 75% = \$645.70		
	HIP, diagnostic art the hip (Anaes.) (A	hroscopy of, not being a service associated with any other arthroscopic procedure of .ssist.)		
49360	Fee: \$349.45	Benefit: 75% = \$262.10		

T8. SUF		NS	15. ORTHOPAEDIC	
		hroscopy of, with synovial biopsy, not be dure of the hip (Anaes.) (Assist.)	ing a service associated with any other	
49363	Fee: \$420.85	Benefit: 75% = \$315.65 85% = \$357.75	5	
		urgery of, other than a service associated sociated with surgery for femoroacetabula	with another arthroscopic procedure of the ar impingement (H) (Anaes.) (Assist.)	
49366	(See para TN.8.127 o Fee: \$621.70	of explanatory notes to this Category) Benefit: 75% = \$466.30		
		KNEE		
		of, involving 1 or more of; capsular releady (Anaes.) (Assist.)	ase, biopsy or lavage, or removal of loose	
49500	Fee: \$382.55	Benefit: 75% = \$286.95		
	chondroplasty of, o	otal meniscectomy of, repair of collateral osteoplasty of, patellofemoral stabilisation which another item in this Group applies)	n or single transfer of ligament or tendon (not	
49503	Fee: \$497.40	Benefit: 75% = \$373.05		
	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) - any 2 or more procedures (Anaes.) (Assist.)			
49506	Fee: \$746.15	Benefit: 75% = \$559.65		
	KNEE, total synov	ectomy or arthrodesis with synovectomy	if performed (Anaes.) (Assist.)	
49509	Fee: \$765.30	Benefit: 75% = \$574.00		
	KNEE, arthrodesis	of, with synovectomy if performed, with	removal of prosthesis (Anaes.) (Assist.)	
49512	Fee: \$1,100.00	Benefit: 75% = \$825.00		
	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.) (Assist.)			
49515	Fee: \$860.90	Benefit: 75% = \$645.70		
	KNEE, hemiarthro	plasty of (Anaes.) (Assist.)		
49517	Fee: \$1,225.65	Benefit: 75% = \$919.25		
19917		ement arthroplasty of (Anaes.) (Assist.)		
49518	Fee: \$1,338.90	Benefit: 75% = \$1004.20		
47518			ed minor grafting, if performed - bilateral	
49519	Fee: \$2,352.35	Benefit: 75% = \$1764.30		
		ement arthroplasty of, requiring major bo	one grafting to femur or tibia, including	
49521	Fee: \$1,626.25	Benefit: 75% = \$1219.70		
49524		ement arthroplasty of, requiring major bo	one grafting to femur and tibia, including	

T8. SUF	GICAL OPERATIO	DNS 15. ORTHOPAEDIC		
	obtaining of graft	(Anaes.) (Assist.)		
	Fee: \$1,913.10	Benefit: 75% = \$1434.85		
	KNEE, total replac (Assist.)	cement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)		
49527	Fee: \$1,626.25	Benefit: 75% = \$1219.70		
		cement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, g of graft and including removal of prosthesis (Anaes.) (Assist.)		
49530	Fee: \$2,008.85	Benefit: 75% = \$1506.65		
		cement arthroplasty of, revision procedure, requiring bone grafting to both femur and taining of graft and including removal of prosthesis (Anaes.) (Assist.)		
49533	Fee: \$2,295.80	Benefit: 75% = \$1721.85		
	KNEE, patello-fer	noral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.)		
49534	Fee: \$456.75	Benefit: 75% = \$342.60		
	cruciate or collater	econstruction of, for chronic instability (open or arthroscopic, or both) involving either ral ligaments, including notchplasty when performed, not being a service associated proscopic procedure of the knee (Anaes.) (Assist.)		
49536	Fee: \$956.50	Benefit: 75% = \$717.40		
	KNEE, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service to which another item in this Group applies or a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)			
49539	Fee: \$956.50	Benefit: 75% = \$717.40		
	including notchpla	tive surgery to cruciate ligament or ligaments (open or arthroscopic, or both), asty, meniscus repair, extracapsular procedure and debridement when performed, not sociated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)		
49542	Fee: \$1,338.90	Benefit: 75% = \$1004.20		
	KNEE, revision ar	throdesis of, with synovectomy if performed (Anaes.) (Assist.)		
49545	Fee: \$765.30	Benefit: 75% = \$574.00		
	KNEE, revision of	f patello-femoral stabilisation (Anaes.) (Assist.)		
49548	Fee: \$956.50	Benefit: 75% = \$717.40		
	KNEE, revision of	f procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.)		
49551	Fee: \$1,338.90	Benefit: 75% = \$1004.20		
	KNEE, revision of (Assist.)	f total replacement of, by anatomic specific allograft of tibia or femur (Anaes.)		
49554	Fee: \$1,913.10	Benefit: 75% = \$1434.85		
49557	being a service ass	arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not sociated with autologous chondrocyte implantation or matrix-induced autologous antation or any other arthroscopic procedure of the knee region (Anaes.) (Assist.)		

T8. SUR	RGICAL OPERAT	IONS	15. ORTHOPAEDIC	
	(See para TN.8.117 Fee: \$277.30	7 of explanatory notes to this Category) Benefit: 75% = \$208.00		
		pic surgery of, involving 1 or more of: debridement ny other arthroscopic procedure of the knee regio		
49558	Fee: \$277.30	Benefit: 75% = \$208.00		
	similar) implant;	pic surgery of, involving chondroplasty requiring including any associated debridement or oestopla redure of the knee region (Anaes.) (Assist.)		
49559	Fee: \$415.25	Benefit: 75% = \$311.45		
		pic surgery of, involving 1 or more of: partial or lease - not being a service associated with any oth Assist.)		
49560	Fee: \$560.45	Benefit: 75% = \$420.35		
	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)			
49561	Fee: \$684.80	Benefit: 75% = \$513.60		
	removal of loose drilling or carbor	DSCOPIC SURGERY OF, involving 1 or more o body or lateral release; where the procedure inclu- n fibre (or similar) implant and associated debride throscopic procedure of the knee region (Anaes.)	udes chondroplasty requiring multiple ment or osteoplasty - not associated	
49562	Fee: \$747.25	Benefit: 75% = \$560.45		
	KNEE, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft (excluding autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation) -not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)			
49563	(See para TN.8.117 Fee: \$809.45	7 of explanatory notes to this Category) Benefit: 75% = \$607.10		
	release, medial c	emoral stabilisation of, combined arthroscopic and apsulorrhaphy and tendon transfer, not being a ser- cedure of the knee (Anaes.) (Assist.)		
49564	Fee: \$933.75	Benefit: 75% = \$700.35		
	KNEE, arthroscopic total synovectomy of, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)		ociated with any other arthroscopic	
49566	Fee: \$765.30	Benefit: 75% = \$574.00		
	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty (Anaes.) (Assist.)			
49569	Fee: \$765.30	Benefit: 75% = \$574.00		
		ANKLE		
49700	ANKLE, diagnos	stic arthroscopy of, including biopsy (Anaes.) (As	ssist.)	

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	Fee: \$277.30	Benefit: 75% = \$208.00
	ANKLE, arthros of the ankle (Ana	copic surgery of, not being a service associated with any other arthroscopic procedure aes.) (Assist.)
49703	Fee: \$621.70	Benefit: 75% = \$466.30
	ANKLE, arthroto (Anaes.) (Assist.	omy of, involving 1 or more of: lavage, removal of loose body or division of contracture)
49706	Fee: \$334.85	Benefit: 75% = \$251.15
	ANKLE, ligamer	ntous stabilisation of (Anaes.) (Assist.)
49709	Fee: \$717.35	Benefit: 75% = \$538.05
	ANKLE, arthrod	esis of, with synovectomy if performed (Anaes.) (Assist.)
49712	Fee: \$765.30	Benefit: 75% = \$574.00
	ANKLE, total jo	int replacement of (Anaes.) (Assist.)
49715	Fee: \$1,147.70	Benefit: 75% = \$860.80
	ANKLE, total re (Assist.)	placement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)
49716	Fee: \$1,515.00	Benefit: 75% = \$1136.25
		placement arthroplasty of, revision procedure, requiring bone grafting, including hesis (Anaes.) (Assist.)
49717	Fee: \$1,818.00	Benefit: 75% = \$1363.50
	ANKLE, Achille	s' tendon or other major tendon, repair of (Anaes.) (Assist.)
49718	Fee: \$382.55	Benefit: 75% = \$286.95
	ANKLE, Achille	s' tendon rupture managed by non-operative treatment
49721	Fee: \$239.25	Benefit: 75% = \$179.45 85% = \$203.40
	ANKLE, Achille	s' tendon, secondary repair or reconstruction of (Anaes.) (Assist.)
49724	Fee: \$669.70	Benefit: 75% = \$502.30
		s' tendon, operation for lengthening (Anaes.) (Assist.)
49727	Fee: \$286.85	Benefit: 75% = \$215.15
	ANKLE, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Anaes.) (Assist.)	
49728	Fee: \$573.75	Benefit: 75% = \$430.35
		FOOT
	FOOT, flexor or	extensor tendon, primary repair of (Anaes.)
49800	Fee: \$133.95	Benefit: 75% = \$100.50 85% = \$113.90
	FOOT, flexor or	extensor tendon, secondary repair of (Anaes.)
49803	Fee: \$172.20	Benefit: 75% = \$129.15 85% = \$146.40

T8. SUF	GICAL OPERATI	ONS	15. ORTHOPAEDIC
	FOOT, subcutant	eous tenotomy of, 1 or more tendons (Anaes.)	
49806	Fee: \$133.95	Benefit: 75% = \$100.50 85% = \$113.90	
	FOOT, open tenotomy of, with or without tenoplasty (Anaes.)		
49809	Fee: \$219.95	Benefit: 75% = \$165.00	
	FOOT, tendon or applies (Anaes.) (ligament transplantation of, not being a service to v (Assist.)	which another item in this Group
49812	Fee: \$439.90	Benefit: 75% = \$329.95	
	FOOT, triple arth	rodesis of, with synovectomy if performed (Anaes.) (Assist.)
49815	Fee: \$765.30	Benefit: 75% = \$574.00	
	FOOT, excision of	of calcaneal spur (Anaes.) (Assist.)	
49818	Fee: \$277.30	Benefit: 75% = \$208.00	
		n of hallux valgus or hallux rigidus by excision arthrateral (Anaes.) (Assist.)	roplasty (Keller's or similar
49821	Fee: \$439.90	Benefit: 75% = \$329.95	
		n of hallux valgus or hallux rigidus by excision arth eral (Anaes.) (Assist.)	roplasty (Keller's or similar
49824	Fee: \$770.10	Benefit: 75% = \$577.60	
	FOOT, correction	n of hallux valgus by transfer of adductor hallucis te	endon - unilateral (Anaes.) (Assist.)
49827	Fee: \$478.25	Benefit: 75% = \$358.70	
	FOOT, correction	n of hallux valgus by transfer of adductor hallucis te	endon - bilateral (Anaes.) (Assist.)
49830	Fee: \$836.95	Benefit: 75% = \$627.75	
		n of hallux valgus by osteotomy of first metatarsal v xcision of exostoses associated with the first metata	
49833	Fee: \$526.10	Benefit: 75% = \$394.60	
	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.)		
49836	Fee: \$908.70	Benefit: 75% = \$681.55	
	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.)		
49837	Fee: \$657.60	Benefit: 75% = \$493.20	
	tendon, with or w	n of hallux valgus by osteotomy of first metatarsal a rithout internal fixation and with or without excision alangeal joint - bilateral (Anaes.) (Assist.)	
49838	Fee: \$1,135.65	Benefit: 75% = \$851.75	
49839	FOOT, correction	n of hallux rigidus or hallux valgus by prosthetic art	hroplasty - unilateral (Anaes.)

T8. SUF	GICAL OPERAT	IONS 15. ORTHOPAEDIC
	(Assist.)	
	Fee: \$526.10	Benefit: 75% = \$394.60
	FOOT, correction (Assist.)	n of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.)
49842	Fee: \$908.70	Benefit: 75% = \$681.55
	FOOT, arthrodes	is of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.)
49845	Fee: \$478.25	Benefit: 75% = \$358.70
	FOOT, correction	n of claw or hammer toe (Anaes.)
49848	Fee: \$162.60	Benefit: 75% = \$121.95 85% = \$138.25
	FOOT, correction	n of claw or hammer toe with internal fixation (Anaes.)
49851	Fee: \$210.30	Benefit: 75% = \$157.75
		antar fasciotomy or fasciectomy of (Anaes.) (Assist.)
49854	Fee: \$382.55	Benefit: 75% = \$286.95
+705+		p-phalangeal joint replacement (Anaes.) (Assist.)
10957		
49857	Fee: \$353.90	Benefit: 75% = \$265.45 omy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.)
49860	Fee: \$286.85	Benefit: 75% = \$215.15
	FOOT, synovect	omy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.)
49863	Fee: \$430.55	Benefit: 75% = \$322.95
	FOOT, neurector	my for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.)
49866	Fee: \$305.85	Benefit: 75% = \$229.40
		NOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or ach attendance (Anaes.)
49878	Fee: \$57.40	Benefit: 75% = \$43.05 85% = \$48.80
		OTHER JOINTS
	JOINT, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Anaes.) (Assist.)	
50100	Fee: \$277.30	Benefit: 75% = \$208.00 85% = \$235.75
	JOINT, arthrosco (Assist.)	ppic surgery of, not being a service to which another item in this Group applies (Anaes.)
50102	Fee: \$621.70	Benefit: 75% = \$466.30
		ny of, not being a service to which another item in this Group applies (Anaes.) (Assist.)
50103	Fee: \$334.85	Benefit: 75% = \$251.15
50105		romy of, not being a service to which another item in this Group applies (Anaes.)

18. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	(Assist.)	
	Fee: \$317.30	Benefit: 75% = \$238.00 85% = \$269.75
		ion of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, ce to which another item in this Group applies (Anaes.) (Assist.)
50106	Fee: \$478.25	Benefit: 75% = \$358.70
		sis of, not being a service to which another item in this Group applies, with performed (Anaes.) (Assist.)
50109	Fee: \$478.25	Benefit: 75% = \$358.70
		FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving an skin and subcutaneous tissue, not being a service to which another item in this Group (Assist.)
50112	Fee: \$366.85	Benefit: 75% = \$275.15
		S, manipulation of, performed in the operating theatre of a hospital, not being a service service to which another item in this Group applies (Anaes.)
50115	Fee: \$145.25	Benefit: 75% = \$108.95
	SUBTALAR JO	INT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)
50118	Fee: \$439.90	Benefit: 75% = \$329.95
	GREATER TRO	CHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.)
50121	Fee: \$860.90	Benefit: 75% = \$645.70
	JOINT OR JOIN (Anaes.) (Assist.	TS, arthroplasty of, by any technique not being a service to which another item applies
50127	Fee: \$713.75	Benefit: 75% = \$535.35
	JOINT OR JOIN (Assist.)	TS, application of external fixator to, other than for treatment of fractures (Anaes.)
50130	Fee: \$317.30	Benefit: 75% = \$238.00
		MALIGNANT DISEASE
		DR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, cluding aftercare) (Anaes.)
50200	Fee: \$191.20	Benefit: 75% = \$143.40 85% = \$162.55
	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, involving neurovascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.)	
50201	Fee: \$334.75	Benefit: 75% = \$251.10
	BONE OR MAL (Assist.)	IGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.)
50203	Fee: \$420.90	Benefit: 75% = \$315.70 85% = \$357.80
		R, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, ft or cementation (Anaes.) (Assist.)
	Fee: \$621.70	Benefit: 75% = \$466.30

T8. SUF		ONS 15. ORTHOPAEDIC
		t, allograft or cementation (Anaes.) (Assist.)
50209	Fee: \$765.30	Benefit: 75% = \$574.00
		AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, f, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.)
50212	Fee: \$1,673.90	Benefit: 75% = \$1255.45
	enbloc resection of	AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, of, with compartmental or wide excision of soft tissue, with intercalary reconstruction aft or autograft) (Anaes.) (Assist.)
50215	Fee: \$2,104.35	Benefit: 75% = \$1578.30
		UMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of h synovectomy if performed (Anaes.) (Assist.)
50218	Fee: \$2,774.00	Benefit: 75% = \$2080.50
		AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or HOULDER, enbloc resection of (Anaes.) (Assist.)
50221	Fee: \$2,582.50	Benefit: 75% = \$1936.90
		AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or HOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or (Assist.)
50224	Fee: \$2,869.55	Benefit: 75% = \$2152.20 85% = \$2784.85
		ONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or without prosthetic replacement (Anaes.) (Assist.)
50227	Fee: \$3,347.80	Benefit: 75% = \$2510.85
	BENIGN TUMO (Anaes.) (Assist.)	UR, resection of, requiring anatomic specific allograft, with or without internal fixation
50230	Fee: \$1,721.70	Benefit: 75% = \$1291.30
	MALIGNANT T	UMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.)
50233	Fee: \$2,200.00	Benefit: 75% = \$1650.00
	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal this femur (Anaes.) (Assist.)	
50236	Fee: \$1,721.70	Benefit: 75% = \$1291.30
	MALIGNANT T applies (Anaes.) (UMOUR, amputation for, not being a service to which another item in this Group Assist.)
50239	Fee: \$1,147.70	Benefit: 75% = \$860.80
		LIMB LENGTHENING AND DEFORMITY CORRECTION
		ITY, slow correction of, using ring fixator or similar device, including all associated able only once in any 12 month period (Anaes.) (Assist.)
50300	Fee: \$1,176.20	Benefit: 75% = \$882.15

GICAL OPERATI	ONS	15. ORTHOPAEDIC
intra-medullary d	evice, in the operating theatre of a hospital - pay	
Fee: \$1,605.90	Benefit: 75% = \$1204.45	
fixator is extended	d to correct an adjacent joint deformity, or where	
Fee: \$2,507.40	Benefit: 75% = \$1880.55 85% = \$2422.70	
fixation pins, perf	formed under general anaesthesia in the operatin	
Fee: \$309.95	Benefit: 75% = \$232.50	
		ssociated with any other arthroscopic
Fee: \$711.30	Benefit: 75% = \$533.50	
TALIPES EQUIN	NOVARUS, posterior release of (Anaes.) (Assist	t.)
Fee: \$704.40	Benefit: 75% = \$528.30	
TALIPES EQUIN		
Fee: \$704.40	Benefit: 75% = \$528.30	
	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.)	
Fee • \$943 70	Benefit: 75% - \$707.80	
		f, revision procedure (Anaes.) (Assist.)
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		st)
	- · · · ·	
TALIPES EQUINOVARUS, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes.)		tre of a hospital, not being a service to
Fee: \$232.35	Benefit: 75% = \$174.30	
TARSAL COALI (Assist.)	TION, excision of, with interposition of muscle	e, fat graft or similar graft (Anaes.)
Fee: \$626.70	Benefit: 75% = \$470.05	
TALUS, VERTIC (Assist.)	CAL, CONGENITAL, combined anterior and po	osterior reconstruction (Anaes.)
Fee: \$936.80	Benefit: 75% = \$702.60	
FOOT AND ANH (Assist.)	KLE, tibialis anterior tendon (split or whole) tran	nsfer to lateral column (Anaes.)
Fee: \$570.55	Benefit: 75% = \$427.95	
	 LIMB LENGTHE intra-medullary de month period (An Fee: \$1,605.90 LIMB LENGTHE fixator is extended (Anaes.) (Assist.) Fee: \$2,507.40 RING FIXATOR fixation pins, perf service to which i Fee: \$309.95 ANKLE, synoved procedure of the a Fee: \$711.30 TALIPES EQUIN Fee: \$704.40 TALIPES EQUIN Fee: \$704.40 TALIPES EQUIN Fee: \$943.70 TALIPES EQUIN Fee: \$1,345.35 TALIPES EQUIN Fee: \$1,641.00 TALIPES EQUIN Fee: \$1,641.00 TALIPES EQUIN Fee: \$1,642.35 TALIPES EQUIN Fee: \$232.35 TARSAL COALI (Assist.) Fee: \$936.80 FOOT AND ANE (Assist.) 	LIMB LENGTHENING, 5cm or less, by gradual distraction, with intra-medullary device, in the operating theatre of a hospital - pay month period (Anaes.) (Assist.)Fee: \$1,605.90 Benefit: 75% = \$1204.45LIMB LENGTHENING, where the lengthening is bipolar, or bo fixator is extended to correct an adjacent joint deformity, or wher (Anaes.) (Assist.)Fee: \$2,507.40 Benefit: 75% = \$1880.55 85% = \$2422.70RING FIXATOR OR SIMILAR DEVICE, adjustment of, with or fixation pins, performed under general anaesthesia in the operatin service to which item 50303 or 50306 applies (Anaes.) (Assist.)Fee: \$309.95 Benefit: 75% = \$232.50ANKLE, synovectomy of, by arthroscopic or open means - not as procedure of the ankle (Anaes.) (Assist.)Fee: \$711.30 Benefit: 75% = \$533.50TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.)Fee: \$704.40 Benefit: 75% = \$528.30TALIPES EQUINOVARUS, combined postero-medial release of Fee: \$943.70 Benefit: 75% = \$1009.05TALIPES EQUINOVARUS, combined postero-medial release of Fee: \$1.345.35 Benefit: 75% = \$1009.05TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist Fee: \$1.641.00 Benefit: 75% = \$1230.75TALIPES EQUINOVARUS, ot talus, vertical congenital - post o plaster, performed under general anaesthesia in the operating thea which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes Maces.)Fee: \$223.35 Benefit: 75% = \$174.30TASAL COALITION, excision of, with interposition of muscle (Assist.)Fee: \$936.80 Benefit: 75% = \$702.60FOOT AND ANKLE, tibialis anterior tendon (split or whole) trat (Assist.)

T8. SUF	GICAL OPERATIC	INS	15. ORTHOPAEDIC		
		LE, tibialis or tibialis posterior tendon transfer, thro or aspect of foot (Anaes.) (Assist.)	bugh the interosseous membrane to		
50342	Fee: \$662.05	Benefit: 75% = \$496.55			
		ON DEFORMITY OF TOE, release incorporating nd release of capsule contracture (Anaes.) (Assist.)			
50345	Fee: \$352.20	Benefit: 75% = \$264.15			
		HIP, KNEE AND LEG PROCEDUR.	ES		
		of, post-operative manipulation and change of plast operating theatre of a hospital (Anaes.)	ter, performed under general		
50348	Fee: \$232.35	Benefit: 75% = \$174.30			
	HIP, congenital dis	slocation of, treatment of, by closed reduction (Ana	nes.)		
50349	Fee: \$325.25	Benefit: 75% = \$243.95 85% = \$276.50			
	HIP, developmenta	al dislocation of, open reduction of (Anaes.) (Assist	t.)		
50351	Fee: \$1,622.80	Benefit: 75% = \$1217.10			
		slocation of, treatment of, involving supervision of	splint, harness or cast - each		
50352	Fee: \$57.40	Benefit: 75% = \$43.05 85% = \$48.80			
	HIP SPICA, initial (Assist.)	application of, for congenital dislocation of hip (ex	xcluding aftercare) (Anaes.)		
50353	Fee: \$360.50	Benefit: 75% = \$270.40			
	TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.)				
50354	Fee: \$1,331.10	Benefit: 75% = \$998.35 85% = \$1246.40			
	KNEE, LEG OR T (Anaes.) (Assist.)	HIGH, rectus femoris tendon transfer, or medial or	lateral hamstring tendon transfer		
50357	Fee: \$570.55	Benefit: 75% = \$427.95			
	KNEE, LEG OR T	HIGH, combined medial and lateral hamstring tend	don transfer (Anaes.) (Assist.)		
50360	Fee: \$662.05	Benefit: 75% = \$496.55			
	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilate (Anaes.) (Assist.)		ngthening or tenotomies, unilateral		
50363	Fee: \$507.05	Benefit: 75% = \$380.30			
	KNEE, contracture (Anaes.) (Assist.)	e of, posterior release involving multiple tendon len	gthening or tenotomies, bilateral		
50366	Fee: \$887.45	Benefit: 75% = \$665.60			
50369		e of, posterior release involving multiple tendon len ease of joint capsule with or without cruciate ligam			

			15. ORTHOPAEDIC
	Fee: \$662.05	Benefit: 75% = \$496.55	
		re of, posterior release involving multiple tendon lengther elease of joint capsule with or without cruciate ligaments,	
50372	Fee: \$1,162.10	Benefit: 75% = \$871.60	
		of, medial release, involving lengthening of, or division of on of the obturator nerve, unilateral (Anaes.) (Assist.)	of the adductors and psoas with
50375	Fee: \$507.05	Benefit: 75% = \$380.30	
		of, medial release, involving lengthening of, or division of on of the obturator nerve, bilateral (Anaes.) (Assist.)	of the adductors and psoas with
50378	Fee: \$887.45	Benefit: 75% = \$665.60	
		of, anterior release, involving lengthening of, or division livision of the joint capsule, unilateral (Anaes.) (Assist.)	of the hip flexors and psoas
50381	Fee: \$662.05	Benefit: 75% = \$496.55	
		of, anterior release, involving lengthening of, or division livision of the joint capsule, bilateral (Anaes.) (Assist.)	of the hip flexors and psoas
50384	Fee: \$1,162.10	Benefit: 75% = \$871.60	
	HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to great trochanter, or transfer of adductors to ischium (Anaes.) (Assist.)		al musculature to greater
50387	Fee: \$662.05	Benefit: 75% = \$496.55	
		EBRAL PALSY, or other neuromuscular conditions, affe st under general anaesthesia, performed in the operating th	
50390	Fee: \$232.35	Benefit: 75% = \$174.30	
	PELVIS, bone gr	raft or shelf procedures for acetabular dysplasia (Anaes.) ((Assist.)
50393	Fee: \$859.15	Benefit: 75% = \$644.40	
		DYSPLASIA, treatment of, by multiple peri-acetabular or erformed (Anaes.) (Assist.)	osteotomy, including internal
50394	Fee: \$2,821.75	Benefit: 75% = \$2116.35	
		SHOULDER, ARM AND FOREARM PROCEDU	JRES
		al abnormalities or duplication of digits, amputation or sp igament or joint reconstruction (Anaes.) (Assist.)	litting of phalanx or
50396	Fee: \$472.00	Benefit: 75% = \$354.00	
	FOREARM, RA (Anaes.) (Assist.)	DIAL APLASIA OR DYSPLASIA (radial club hand), ces)	ntralisation or radialisation of
50399	Fee: \$936.80	Benefit: 75% = \$702.60	
	TODTICOLLIC	bipolar release of sternocleidomastoid muscle and associa	. 1

T8. SUF	RGICAL OPERAT	ONS	15. ORTHOPAEDIC	
	Fee: \$429.70	Benefit: 75% = \$322.30		
	ELBOW, flexorp	lasty, or tendon transfer to restore	re elbow function (Anaes.) (Assist.)	
50405	Fee: \$584.60	Benefit: 75% = \$438.45		
	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.)			
50408	Fee: \$1,014.20	Benefit: 75% = \$760.65		
	AMPUTATION	IS OR RECONSTRUCTIONS F /, treatment of congenital deficien	FOR CONGENITAL DEFORMITIES LOWER LIMB ncy of the femur by resection of the distal femur and y knee fusion (Anaes.) (Assist.)	
50411	Fee: \$1,331.10	Benefit: 75% = \$998.35 85%	6 = \$1246.40	
			genital deficiency of the femur by resection of the distal and rotationplasty (Anaes.) (Assist.)	
50414	Fee: \$1,795.90	Benefit: 75% = \$1346.95 85	5 % = \$1711.20	
			genital deficiency of the tibia by reconstruction of the air of quadriceps mechanism (Anaes.) (Assist.)	
50417	Fee: \$1,331.10	Benefit: 75% = \$998.35 85%	6 = \$1246.40	
	PATELLA, cong	enital dislocation of, reconstructi	ion of the quadriceps (Anaes.) (Assist.)	
50420	Fee: \$1,098.65	Benefit: 75% = \$824.00		
	TIBIA, FIBULA fixation (Anaes.)		ey of, transfer of the fibula to tibia, with internal	
50423	Fee: \$1,014.20	Benefit: 75% = \$760.65 85%	6 = \$929.50	
		TUMOROU	IS CONDITIONS	
	DIAPHYSEAL	ACLASIA, removal of lesion or le	lesions from bone - 1 approach (Anaes.) (Assist.)	
50426	Fee: \$472.00	Benefit: 75% = \$354.00		
	SINGL	E EVEN MULTILEVEL SURGER	Y FOR CHILDREN WITH CEREBRAL PALSY	
		SINGLE EVENT MULTILEVEL ral palsy comprising three or more	L SURGERY for patients less than 18 years of age with re of the following:	
	(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.			
	(b) Correction of muscle imbalance by tendon transfer/transfers.			
	(c) Correction	of femoral torsion by rotational of	steotomy of the femur.	
	(d) Correction	of tibial torsion by rotational oste	eotomy of the tibia.	
		of joint instability by varus derota if performed, or os calcis length	ation osteotomy of the femur, subtalar arthrodesis, with nening.	
50450	Conjoint surgery	principal specialist surgeon, incl	luding fluoroscopy and aftercare (Anaes.) (Assist.)	

T8. SUF	GICAL OPERATIONS	15. ORTHOPAEDIC
	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,246.55 Benefit: 75% = \$934.95	
	UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less hemiplegic cerebral palsy comprising three or more of the following:	ss than 18 years of age with
	(a) Lengthening of one or more contracted muscle tendon units by tendon le recession, fractional lengthening or intramuscular lengthening.	engthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of femoral torsion by rotational osteotomy of the femur.	
	(d) Correction of tibial torsion by rotational osteotomy of the tibia.	
	(e) Correction of joint instability by varus derotation osteotomy of the femu synovectomy if performed, or os calcis lengthening.	r, subtalar arthrodesis, with
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and exclu (Assist.)	iding aftercare (Anaes.)
50451	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,246.55 Benefit: 75% = \$934.95	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less diplegic cerebral palsy that comprises:	than 18 years of age with
	(`) Lengthening of one or more contracted muscle tendon units by tendon le recession, fractional lengthening or intramuscular lengthening.	ngthening, muscle
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and after	rcare (Anaes.) (Assist.)
50455	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,411.65 Benefit: 75% = \$1058.75	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less diplegic cerebral palsy that comprises:	than 18 years of age with
	(a) Lengthening of one or more contracted muscle tendon units by tendon le recession, fractional lengthening or intramuscular lengthening.	engthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and exclu (Assist.)	nding aftercare (Anaes.)
50456	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,411.65 Benefit: 75% = \$1058.75	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilatera	
	() Lengthening of one or more contracted muscle tendon units by tendon le recession, fractional lengthening or intramuscular lengthening.	ngthening, muscle
50460	() Correction of muscle imbalance by tendon transfer/transfers.	

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	() Correction of torsional abnormality of the femur by rotational of	osteotomy and internal fixation.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy	v and aftercare (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,107.65 Benefit: 75% = \$1580.75	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for pat diplegic cerebral palsy that comprises bilateral soft tissue surgery an	
	(a) Lengthening of one or more contracted muscle tendon units by recession, fractional lengthening or intramuscular lengthening.	tendon lengthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of torsional abnormality of the femur by rotational o	steotomy and internal fixation.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy (Assist.)	and excluding aftercare (Anaes.)
50461	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,107.65 Benefit: 75% = \$1580.75	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for pat diplegic cerebral palsy that comprises bilateral soft tissue surgery, bi bilateral tibial osteotomies.	
	() Lengthening of one or more contracted muscle tendon units by recession, fractional lengthening or intramuscular lengthening.	tendon lengthening, muscle
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	(`) Correction of abnormal torsion of the femur by rotational osteo	tomy with internal fixation.
	() Correction of abnormal torsion of the tibia by rotational osteoto	my with internal fixation.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy	v and aftercare (Anaes.) (Assist.)
50465	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,968.55 Benefit: 75% = \$2226.45	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for pat diplegic cerebral palsy that comprises bilateral soft tissue surgery, bi bilateral tibial osteotomies.	
	(a) Lengthening of one or more contracted muscle tendon units by recession, fractional lengthening or intramuscular lengthening.	tendon lengthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of abnormal torsion of the femur by rotational osteo	tomy with internal fixation.
	(d) Correction of abnormal torsion of the tibia by rotational osteoto	omy with internal fixation.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy (Assist.)	and excluding aftercare (Anaes.)
50466	(See para TN.8.118 of explanatory notes to this Category)	

T8. SUF	GICAL OPERATIONS	15. ORTHOPAEDIC		
	Fee: \$2,968.55 Benefit: 75% = \$2226.45			
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patiencerebral palsy that comprises bilateral soft tissue surgery, bilateral femosteotomies and bilateral foot stabilisation.			
	() Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.			
	(`) Correction of muscle imbalance by tendon transfer/transfers.			
	() Correction of abnormal torsion of the femur by rotational osteotor	my with internal fixation.		
	(`) Correction of abnormal torsion of the tibia by rotational osteotom	y with internal fixation.		
	() Correction of bilateral pes valgus by os calcis lengthening or subt	alar fusion.		
	Conjoint surgery, principal specialist surgeon, including fluoroscopy as	nd aftercare (Anaes.) (Assist.)		
50470	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,764.85 Benefit: 75% = \$2823.65			
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patier cerebral palsy that comprises bilateral soft tissue surgery, bilateral fem- osteotomies and bilateral foot stabilisation.			
	(a) Lengthening of one or more contracted muscle tendon units by terrecession, fractional lengthening or intramuscular lengthening.	ndon lengthening, muscle		
	(b) Correction of muscle imbalance by tendon transfer/transfers.			
	(c) Correction of abnormal torsion of the femur by rotational osteotor	my with internal fixation.		
	(d) Correction of abnormal torsion of the tibia by rotational osteotom	y with internal fixation.		
	(e) Correction of bilateral pes valgus by os calcis lengthening or subt	alar fusion.		
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy an (Assist.)	nd excluding aftercare (Anaes.)		
50471	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,764.85 Benefit: 75% = \$2823.65			
	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 cerebral palsy for the correction of crouch gait including:	years of age with diplegic		
	() Lengthening of one or more contracted muscle tendon units by ter recession, fractional lengthening or intramuscular lengthening.	ndon lengthening, muscle		
	() Correction of muscle imbalance by tendon transfer/transfers.			
	(`) Correction of flexion deformity at the knee by extension osteotom internal fixation.	ny of the distal femur including		
	() Correction of patella alta and quadriceps insufficiency by patella t	tendon shortening/reconstruction.		
50475	() Correction of tibial torsion by rotational osteotomy of the tibia wi	th internal fixation.		

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC
	(`) Correction of foot instability by os calcis lengthening or subtalar fusion.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) Fee: \$4,344.25 Benefit: 75% = \$3258.20
	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including:
	(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(b) Correction of muscle imbalance by tendon transfer/transfers.
	(c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation.
	(d) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction.
	(e) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation.
	(f) Correction of foot instability by os calcis lengthening or subtalar fusion.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)
50476	(See para TN.8.118 of explanatory notes to this Category) Fee: \$4,344.25 Benefit: 75% = \$3258.20
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS
	RADIUS OR ULNA, distal end of, <i>with open growth plate</i> , treatment of fracture of, by closed reduction (Anaes.)
50500	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$281.10 Benefit: 75% = \$210.85 85% = \$238.95
	RADIUS OR ULNA, distal end of, <i>with open growth plate</i> , treatment of fracture of, by open reduction (Anaes.) (Assist.)
50504	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$374.95 Benefit: 75% = \$281.25 85% = \$318.75
	RADIUS, distal end of, <i>with open growth plate</i> , treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.)
50508	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$401.55 Benefit: 75% = \$301.20 85% = \$341.35
	RADIUS, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.)
50512	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$535.75 Benefit: 75% = \$401.85
	RADIUS OR ULNA, shaft of, <i>with open growth plate</i> , treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)
50516	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: $$361.55$ Benefit: $75\% = 271.20

T8. SUF	RGICAL OPERATIONS 15. C	ORTHOPAEDIC
	RADIUS OR ULNA, shaft of, <i>with open growth plate</i> , treatment of fracture of, by open (Anaes.) (Assist.)	reduction
50520	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$482.00 Benefit: 75% = \$361.50	
	RADIUS OR ULNA, shaft of, <i>with open growth plate</i> , treatment of fracture of, in conjudislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Mont closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.)	
50524	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$415.05 Benefit: 75% = \$311.30	
	RADIUS OR ULNA, shaft of, <i>with open growth plate</i> , treatment of fracture of, in conju dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Mont reduction with or without internal fixation by open or percutaneous means (Anaes.) (As	eggia injury), by
50528	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$669.55 Benefit: 75% = \$502.20	
	RADIUS AND ULNA, shafts of, <i>with open growth plates</i> , treatment of fracture of, by c undertaken in the operating theatre of a hospital (Anaes.)	losed reduction
50532	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$582.55 Benefit: 75% = \$436.95	
	RADIUS AND ULNA, shafts of, <i>with open growth plates</i> , treatment of fracture of, by c (Anaes.) (Assist.)	ppen reduction
50536	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$776.65 Benefit: 75% = \$582.50	
	OLECRANON, with open growth plate, treatment of fracture of, by open reduction (An	aes.) (Assist.)
50540	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$535.75 Benefit: 75% = \$401.85	
	RADIUS, <i>with open growth plate</i> , treatment of fracture of head or neck of, by closed red (Anaes.)	duction of
50544	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$267.80 Benefit: 75% = \$200.85 85% = \$227.65	
	RADIUS, <i>with open growth plate</i> , treatment of fracture of head or neck of, by reduction internal fixation by open or percutaneous means (Anaes.) (Assist.)	with or without
50548	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$535.75 Benefit: 75% = \$401.85	
	HUMERUS, proximal, <i>with open growth plate</i> , treatment of fracture of, by closed reduction in the operating theatre, neonatal unit or nursery of a hospital (Anaes.)	ction, undertaken
50552	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$462.05 Benefit: 75% = \$346.55	
	HUMERUS, proximal, <i>with open growth plate</i> , treatment of fracture of, by open reducti (Assist.)	on (Anaes.)
50556	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$615.90 Benefit: 75% = \$461.95	
50560	HUMERUS, shaft of, with open growth plate, treatment of fracture of, by closed reduction	ion, undertaken

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAE	DIC
	in the operating theatre, neonatal unit or nursery of a hospital (Anaes.)	
	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$482.00 Benefit: 75% = \$361.50	
	HUMERUS, shaft of, <i>with open growth plate</i> , treatment of fracture of, by internal or external fixatio (Anaes.) (Assist.)	'n
50564	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$642.75 Benefit: 75% = \$482.10	
	HUMERUS, <i>with open growth plate</i> , supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	
50568	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$562.45 Benefit: 75% = \$421.85	
	HUMERUS, <i>with open growth plate</i> , supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatree hospital (Anaes.) (Assist.)	
50572	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$749.90 Benefit: 75% = \$562.45	
	FEMUR, <i>with open growth plate</i> , treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)	
50576	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$615.90 Benefit: 75% = \$461.95 85% = \$531.20	
	TIBIA, <i>with open growth plate</i> , plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)	
50580	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$642.75 Benefit: 75% = \$482.10	
	TIBIA, distal, <i>with open growth plate</i> , treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)	
50584	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$615.90 Benefit: 75% = \$461.95	
	TIBIA AND FIBULA, <i>with open growth plates</i> , treatment of fracture of, by internal fixation (Anaes (Assist.)	.)
50588	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$803.35 Benefit: 75% = \$602.55	
	SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS	
	SCOLIOSIS OR KYPHOSIS, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Anaes.) (Assist.)	
50600	(See para TN.8.118 of explanatory notes to this Category) Fee: \$441.65 Benefit: 75% = \$331.25	
	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.)	
50604	(See para TN.8.118 of explanatory notes to this Category)Fee: $$1,874.55$ Benefit: $75\% = 1405.95	
50608	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, treatment by segmental instrumentation and	

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	fusion of the spine, not being a service to which item 51011 to 51171 ap	oplies (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,481.80 Benefit: 75% = \$2611.35	
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, with spinal defor instrumentation, utilising separate anterior and posterior approaches, not item 51011 to 51171 applies (Anaes.) (Assist.)	
50612	(See para TN.8.118 of explanatory notes to this Category) Fee: \$4,952.50 Benefit: 75% = \$3714.40	
	SCOLIOSIS, in a child or adolescent, re-exploration for adjustment or re- instrumentation used for correction of spine deformity (Anaes.) (Assist.)	
50616	(See para TN.8.118 of explanatory notes to this Category) Fee: \$629.25 Benefit: 75% = \$471.95	
	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery osteotomy, fusion, removal of instrumentation or instrumentation, not be 51011 to 51171 applies (Anaes.) (Assist.)	
50620	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,481.80 Benefit: 75% = \$2611.35	
	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion Zielke or similar) - not more than 4 levels (Anaes.) (Assist.)	and segmental fixation (Dwyer,
50624	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,481.80 Benefit: 75% = \$2611.35	
	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion Zielke or similar) - more than 4 levels (Anaes.) (Assist.)	and segmental fixation (Dwyer,
50628	(See para TN.8.118 of explanatory notes to this Category) Fee: \$4,300.95 Benefit: 75% = \$3225.75	
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmer of the spine down to and including the pelvis or sacrum, not being a serv 51171 applies (Anaes.) (Assist.)	
50632	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,615.60 Benefit: 75% = \$2711.70	
	SCOLIOSIS, in a child or adolescent, requiring anterior decompression resection and instrumentation in the presence of spinal cord involvemen item 51011 to 51171 applies (Anaes.) (Assist.)	
50636	(See para TN.8.118 of explanatory notes to this Category) Fee: \$4,017.35 Benefit: 75% = \$3013.05	
	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion o anterior or posterior approach, not being a service to which item 51011 (Assist.)	
50640	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,220.75 Benefit: 75% = \$1665.60	
	SPINE, bone graft to, for a child or adolescent, associated with surgery the kyphosis or both (Anaes.) (Assist.)	for correction of scoliosis or
50644	(See para TN.8.118 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	Fee: \$2,142.70 Benefit: 75% = \$1607.05	
	TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAE	DIATRIC PATIENTS
	HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulat under anaesthesia (Anaes.)	ion and arthrography of the hip
50650	(See para TN.8.118 of explanatory notes to this Category) Fee: \$421.40 Benefit: 75% = \$316.05 85% = \$358.20	
	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplica examination of the hip (Anaes.) (Assist.)	tion of a hip spica, including
50654	(See para TN.8.118 of explanatory notes to this Category) Fee: \$504.60 Benefit: 75% = \$378.45	
	HIP DYSPLASIA or DISLOCATION, in a child, examination and manip anaesthesia (Anaes.)	ulation of the hip under
50658	(See para TN.8.118 of explanatory notes to this Category) Fee: \$200.90 Benefit: 75% = \$150.70 85% = \$170.80	
T8. SUF	16. RADIOFREQ	UENCY AND MICROWAVE TISSUE ABLATION
	Group T8. Surgical Operations	
	Subgroup 16. Radiofrequency And Microwave Tiss	ue Ablation
	Unresectable primary malignant tumour of the liver, destruction of, by per ablation or percutaneous microwave tissue ablation (including any associa than a service associated with a service to which item 30419 or 50952 app	ted imaging services), other
	(Anaes.)	
50950	Fee: \$830.15 Benefit: 75% = \$622.65 85% = \$745.45	
	Unresectable primary malignant tumour of the liver, destruction of, by operadiofrequency ablation or open or laparoscopic microwave tissue ablation imaging services), if a multi-disciplinary team has assessed that percutane percutaneous microwave tissue ablation cannot be performed or is not pratiof the following clinical circumstances:	n (including any associated cous radiofrequency ablation or
	(a) percutaneous access cannot be achieved;	
	(b) vital organs or tissues are at risk of damage from the percutaneous radapercutaneous microwave tissue ablation procedure;	iofrequency ablation or
	(c) resection of one part of the liver is possible, however there is at least o unresectable portion of the liver that is suitable for radiofrequency ablation	
	other than a service associated with a service to which item 30419 or 5095	50 applies.
	(Anaes.)	
50952	(See para TN.8.120 of explanatory notes to this Category)	

T8. SUF	16. RADIOFREQUENCY AND MICRO GICAL OPERATIONS TISSUE ABL	
	Fee: \$830.15 Benefit: 75% = \$622.65 85% = \$745.45	
T8. SUF	GICAL OPERATIONS 17. SPINAL SUI	RGERY
	Group T8. Surgical Operations	
	Subgroup 17. Spinal Surgery	
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or post spinal release, one motion segment, not being a service associated with a service to which item 5 51013, 51014 or 51015 applies (Anaes.) (Assist.)	
51011	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$1,458.45 Benefit: 75% = \$1093.85	
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or poster spinal release, 2 motion segments, not being a service associated with a service to which item 510 51013, 51014 or 51015 applies (Anaes.) (Assist.)	
51012	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$1,944.40 Benefit: 75% = \$1458.30	
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or post spinal release, 3 motion segments, not being a service associated with a service to which item 510 51012, 51014 or 51015 applies (Anaes.) (Assist.)	
51013	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$2,430.55 Benefit: 75% = \$1822.95	
	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.)	
51014	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$2,916.65 Benefit: 75% = \$2187.50	
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or poster spinal release, more than 4 motion segments, not being a service associated with a service to white 51011, 51012, 51013 or 51014 applies (Anaes.) (Assist.)	
51015	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$3,402.75 Benefit: 75% = \$2552.10	
	Simple fixation of part of one vertebra (not motion segment) including pars interarticularis, spino process or pedicle, or simple interspinous wiring between 2 adjacent vertebral levels, not being a associated with:	
	(a) interspinous dynamic stabilisation devices; or	
	(b) a service to which item 51021, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assis	t.)
51020	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$777.70 Benefit: 75% = \$583.30	
	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation ind sublaminar tapes or wires, one motion segment, not being a service associated with a service to w item 51020, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.)	
51021	(See para TN.8.141, TN.8.143 of explanatory notes to this Category)	

T8. SUF	GICAL OPERATIONS	17. SPINAL SURGERY
	Fee: \$1,301.70 Benefit: 75% = \$976.30	
	Fixation of motion segment with vertebral body sc sublaminar tapes or wires, 2 motion segments, not item 51020, 51021, 51023, 51024, 51025 or 51026	
51022	(See para TN.8.141, TN.8.143 of explanatory notes to th Fee: \$1,619.20 Benefit: 75% = \$1214.40	is Category)
		rew, pedicle screw or hook instrumentation including not being a service associated with a service to which applies (Anaes.) (Assist.)
51023	(See para TN.8.141, TN.8.143 of explanatory notes to the Fee: \$1,926.95 Benefit: 75% = \$1445.25	is Category)
		rew, pedicle screw or hook instrumentation including not being a service associated with a service to which applies (Anaes.) (Assist.)
51024	(See para TN.8.141, TN.8.143 of explanatory notes to the Fee: \$2,224.65 Benefit: 75% = \$1668.50	is Category)
	Fixation of motion segment with vertebral body sc sublaminar tapes or wires, 7 to 12 motion segment which item 51020, 51021, 51022, 51023, 51024 or	
51025	(See para TN.8.141, TN.8.143 of explanatory notes to the Fee: \$2,600.15 Benefit: 75% = \$1950.15	is Category)
		rew, pedicle screw or hook instrumentation including gments, not being a service associated with a service or 51025 applies (Anaes.) (Assist.)
51026	(See para TN.8.141, TN.8.143 of explanatory notes to the Fee: \$2,846.75 Benefit: 75% = \$2135.10	is Category)
	Spine, posterior and/or posterolateral bone graft to with a service to which item 51032, 51033, 51034,	one motion segment, not being a service associated 51035 or 51036 applies (Anaes.) (Assist.)
51031	(See para TN.8.141, TN.8.144 of explanatory notes to the Fee: \$956.50 Benefit: 75% = \$717.40	is Category)
	Spine, posterior and/or posterolateral bone graft to with a service to which item 51031, 51033, 51034,	2 motion segments, not being a service associated 51035 or 51036 applies (Anaes.) (Assist.)
51032	(See para TN.8.141, TN.8.144 of explanatory notes to the Fee: \$1,147.85 Benefit: 75% = \$860.90	is Category)
	Spine, posterior and/or posterolateral bone graft to with a service to which item 51031, 51032, 51034,	3 motion segments, not being a service associated 51035 or 51036 applies (Anaes.) (Assist.)
51033	(See para TN.8.141, TN.8.144 of explanatory notes to th Fee: \$1,339.15 Benefit: 75% = \$1004.40	is Category)
	Spine, posterior and/or posterolateral bone graft to associated with a service to which item 51031, 510	, 4 to 7 motion segments, not being a service 32, 51033, 51035 or 51036 applies (Anaes.) (Assist.)
51034	(See para TN.8.141, TN.8.144 of explanatory notes to th Fee: \$1,434.80 Benefit: 75% = \$1076.10	is Category)
51035	Spine, posterior and/or posterolateral bone graft to	8 to 11 motion segments, not being a service

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	associated with a service to which item 51031, 51032, 51033, 510	034 or 51036 applies (Anaes.) (Assist.)
	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,530.40 Benefit: 75% = \$1147.80	
	Spine, posterior and/or posterolateral bone graft to, 12 or more m associated with a service to which item 51031, 51032, 51033, 510	
51036	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,626.10 Benefit: 75% = \$1219.60	
	Spinal fusion, anterior column (anterior, direct lateral or posterior being a service associated with a service to which item 51042, 51 (Assist.)	
51041	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$1,100.00 Benefit: 75% = \$825.00	
	Spinal fusion, anterior column (anterior, direct lateral or posterior being a service associated with a service to which item 51041, 51 (Assist.)	
51042	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$1,540.05 Benefit: 75% = \$1155.05	
	Spinal fusion, anterior column (anterior, direct lateral or posterior being a service associated with a service to which item 51041, 51 (Assist.)	
51043	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$1,925.05 Benefit: 75% = \$1443.80	
	Spinal fusion, anterior column (anterior, direct lateral or posterior being a service associated with a service to which item 51041, 51 (Assist.)	
51044	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$2,090.05 Benefit: 75% = \$1567.55	
	Spinal fusion, anterior column (anterior, direct lateral or posterior segments, not being a service associated with a service to which i applies (Anaes.) (Assist.)	
51045	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$2,200.05 Benefit: 75% = \$1650.05	
	Pedicle subtraction osteotomy, one vertebra, not being a service a item 51052, 51053, 51054, 51055, 51056, 51057, 51058 or 51059	
51051	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$1,879.60 Benefit: 75% = \$1409.70	
	Pedicle subtraction osteotomy, 2 vertebrae, not being a service as item 51051, 51053, 51054, 51055, 51056, 51057, 51058 or 51059	
51052	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,286.00 Benefit: 75% = \$1714.50	
	Vertebral column resection osteotomy performed through single being a service associated with a service to which item 51051, 51 51058 or 51059 applies (Anaes.) (Assist.)	
51053		

T8. SUF	GICAL OPERATIONS	17. SPINAL SURGERY
	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,600.95 Benefit: 75% = \$1950.75	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or su removal of more than 50% of the vertebral body), one vertebra, not being	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51055, 51056, 51057, 5 (Assist.)	51058 or 51059 applies (Anaes.)
51054	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$1,386.85 Benefit: 75% = \$1040.15	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or su removal of more than 50% of the vertebral body), 2 vertebrae, not being a	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51056, 51057, 5 (Assist.)	51058 or 51059 applies (Anaes.)
51055	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,080.25 Benefit: 75% = \$1560.20	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or su removal of more than 50% of the vertebral body), 3 or more vertebrae, no with:	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51057, 5 (Assist.)	51058 or 51059 applies (Anaes.)
51056	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,426.95 Benefit: 75% = \$1820.25	
	Vertebral body, en bloc excision of (complete spondylectomy), one verte associated with:	bra, not being a service
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 5 (Assist.)	51058 or 51059 applies (Anaes.)
51057	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,438.40 Benefit: 75% = \$1828.80	
	Vertebral body, en bloc excision of (complete spondylectomy), 2 vertebra associated with:	ae, not being a service
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 5 (Assist.)	51057 or 51059 applies (Anaes.)
51058	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,743.70 Benefit: 75% = \$2057.80	
51059	Vertebral body, en bloc excision of (complete spondylectomy), 3 or more	e vertebrae, not being a service

T8. SUF	RGICAL OPERATIONS 17. SPINAL SURGER
	associated with:
	(a) anterior column fusion when at the same motion segment; or
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51058 applies (Anaes.) (Assist.)
	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$3,352.80 Benefit: 75% = \$2514.60
	Spinal fusion, anterior and posterior, including spinal instrumentation at one motion segment, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51062, 51063, 51064, 51065 or 51066 applies (Anaes.) (Assist.)
51061	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$2,880.00 Benefit: 75% = \$2160.00
	Spinal fusion, anterior and posterior, including spinal instrumentation at 2 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51063, 51064, 51065 or 51066 applies (Anaes.) (Assist.)
51062	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$3,733.15 Benefit: 75% = \$2799.90
	Spinal fusion, anterior and posterior, including spinal instrumentation at 3 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51064, 51065 or 51066 applies (Anaes.) (Assist.)
51063	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$4,521.55 Benefit: 75% = \$3391.20
	Spinal fusion, anterior and posterior, including spinal instrumentation at 4 to 7 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51065 or 51066 applies (Anaes.) (Assist.)
51064	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$5,032.10 Benefit: 75% = \$3774.10
	Spinal fusion, anterior and posterior, including spinal instrumentation at 8 to 11 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51066 applies (Anaes.) (Assist.)
51065	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$5,565.45 Benefit: 75% = \$4174.10
	Spinal fusion, anterior and posterior, including spinal instrumentation at 12 or more motion segments, posterior and/or posterolateral bone graft, and anterior column fusion not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51065 applies (Anaes.) (Assist.)
51066	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$5,859.80 Benefit: 75% = \$4394.85
	Removal of intradural lesion, not being a service associated with a service to which item 51072 or 51073 applies (Anaes.) (Assist.)
51071	(See para TN.8.141 of explanatory notes to this Category) Fee: \$2,540.00 Benefit: 75% = \$1905.00
	Craniocervical junction lesion, transoral approach for, not being a service associated with a service to which item 51071 or 51073 applies (Anaes.) (Assist.)
51072	

T8. SUF	RGICAL OPERATIONS 17. SPINAL SUR	GERY
	(See para TN.8.141 of explanatory notes to this Category) Fee: \$2,641.60 Benefit: 75% = \$1981.20	
	Removal of intramedullary tumour or arteriovenous malformation, not being a service associated v service to which item 51071 or 51072 applies (Anaes.) (Assist.)	vith a
51073	(See para TN.8.141 of explanatory notes to this Category) Fee: \$3,352.80 Benefit: 75% = \$2514.60	
	Thoracoplasty in combination with thoracic scoliosis correction—3 or more ribs (Anaes.) (Assist.)	
51102	(See para TN.8.141 of explanatory notes to this Category) Fee: \$1,202.35 Benefit: 75% = \$901.80	
	Odontoid screw fixation (Anaes.) (Assist.)	
51103	(See para TN.8.141, TN.8.148 of explanatory notes to this Category) Fee: \$2,113.05 Benefit: 75% = \$1584.80	
	Spine, treatment of fracture, dislocation or fracture dislocation, with immobilisation by calipers or not including application of skull tongs or calipers as part of operative positioning (Anaes.)	halo,
51110	(See para TN.8.141 of explanatory notes to this Category) Fee: \$765.30 Benefit: 75% = \$574.00 85% = \$680.60	
	Skull calipers or halo, insertion of, as an independent procedure (Anaes.)	
51111	(See para TN.8.141 of explanatory notes to this Category) Fee: \$325.25 Benefit: 75% = \$243.95	
	Plaster jacket, application of, as an independent procedure (Anaes.)	
51112	(See para TN.8.141 of explanatory notes to this Category) Fee: \$219.95 Benefit: 75% = \$165.00 85% = \$187.00	
	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.)	
51113	(See para TN.8.141 of explanatory notes to this Category) Fee: \$243.90 Benefit: 75% = \$182.95	
	Halo thoracic orthosis—application of both halo and thoracic jacket (Anaes.)	
51114	(See para TN.8.141 of explanatory notes to this Category) Fee: \$430.55 Benefit: 75% = \$322.95	
	Halo femoral traction, as an independent procedure (Anaes.)	
51115	(See para TN.8.141 of explanatory notes to this Category) Fee: \$430.55 Benefit: 75% = \$322.95 85% = \$366.00	
	Bone graft, harvesting of autogenous graft, via separate incision or via subcutaneous approach, in conjunction with spinal fusion, other than for the purposes of bone graft obtained from the cervical thoracic, lumbar or sacral spine (Anaes.)	L,
51120	(See para TN.8.141 of explanatory notes to this Category) Fee: \$239.25 Benefit: 75% = \$179.45	
	Lumbar artificial intervertebral total disc replacement, at one motion segment only, including remo disc and marginal osteophytes:	oval of
51130	(a) for a patient who:	

T8. SUF	IRGICAL OPERATIONS 17. SPINAL S	URGERY
	(i) has not had prior spinal fusion surgery at the same lumbar level; and	
	(ii) does not have vertebral osteoporosis; and	
	(iii) has failed conservative therapy; and	
	(b) not being a service associated with a service to which item 51011, 51012, 51013, 51014 or applies (Anaes.) (Assist.)	51015
	(See para TN.8.141 of explanatory notes to this Category) Fee: \$1,822.35 Benefit: 75% = \$1366.80	
	Cervical artificial intervertebral total disc replacement, at one motion segment only, including of disc and marginal osteophytes, for a patient who:	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.)	
51131	(See para TN.8.141 of explanatory notes to this Category) Fee: \$1,100.00 Benefit: 75% = \$825.00	
	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation motion segments, not being a service associated with a service to which item 51141 applies (A (Assist.)	
51140	(See para TN.8.141 of explanatory notes to this Category) Fee: \$449.55 Benefit: 75% = \$337.20	
	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation 3 motion segments, not being a service associated with a service to which item 51140 applies ((Assist.)	
51141	(See para TN.8.141 of explanatory notes to this Category) Fee: \$831.65 Benefit: 75% = \$623.75	
	Wound debridement or excision for post operative infection or haematoma following spinal su (Anaes.) (Assist.)	rgery
51145	(See para TN.8.141 of explanatory notes to this Category)Fee: $$449.55$ Benefit: $75\% = 337.20	
	Coccyx, excision of (Anaes.) (Assist.)	
51150	(See para TN.8.141 of explanatory notes to this Category) Fee: \$452.55 Benefit: 75% = \$339.45	
	Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service to whi 51165 applies (Anaes.) (Assist.)	ch item
51160	(See para TN.8.141, TN.8.149 of explanatory notes to this Category) Fee: \$1,168.40 Benefit: 75% = \$876.30	
51165	Anterior exposure of thoracic or lumbar spine, more than one motion segment, not being a serv	vice to

T8. SUF	RGICAL OPERATIONS 17. SPINAL SURGERY
	which item 51160 applies (Anaes.) (Assist.)
	(See para TN.8.141, TN.8.149 of explanatory notes to this Category) Fee: \$1,473.20 Benefit: 75% = \$1104.90
	Syringomyelia or hydromyelia, craniotomy for, with or without duraplasty, intradural dissection, plugging of obex or local cerebrospinal fluid shunt (Anaes.) (Assist.)
51170	(See para TN.8.141 of explanatory notes to this Category)Fee: $$2,219.55$ Benefit: $75\% = 1664.70
	Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid shunt (for example, syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal shunt) (Anaes.) (Assist.)
51171	(See para TN.8.141 of explanatory notes to this Category) Fee: \$932.10 Benefit: 75% = \$699.10
T9. ASS	SISTANCE AT OPERATIONS
	Group T9. Assistance At Operations
	Assistance at any operation identified by the word "Assist." for which the fee does not exceed \$567.25 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed \$567.25
51300	(See para TN.9.2, TN.9.1 of explanatory notes to this Category) Fee: \$87.70 Benefit: 75% = \$65.80 85% = \$74.55
	Assistance at any operation identified by the word "Assist." for which the fee exceeds \$567.25 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds \$567.25.
51303	(See para TN.9.1, TN.9.3 of explanatory notes to this Category) Derived Fee: one fifth of the established fee for the operation or combination of operations
	Assistance at a birth involving Caesarean section
51306	(See para TN.9.1 of explanatory notes to this Category) Fee: \$126.65 Benefit: 75% = \$95.00 85% = \$107.70
	Assistance at a series or combination of operations that include "(Assist.)" and assistance at a birth involving Caesarean section
51309	(See para TN.9.1, TN.9.4 of explanatory notes to this Category) Derived Fee: one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627
51312	(See para TN.4.11, TN.9.1 of explanatory notes to this Category) Derived Fee: one fifth of the established fee for the procedure or combination of procedures
	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779
51315	(See para TN.9.1 of explanatory notes to this Category) Fee: \$276.75 Benefit: 75% = \$207.60 85% = \$235.25
51318	Assistance at cataract and intraocular lens surgery where patient has:

T9. ASS	SISTANCE AT OPERATIONS	
	- total loss of vision, including no potential for central vision, in the fellow eye; or	
	- previous significant surgical complication in the fellow eye; or	
	- pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage	,
	(See para TN.9.5, TN.9.1 of explanatory notes to this Category) Fee: \$182.65 Benefit: 75% = \$137.00 85% = \$155.30	
ANAES ONLY P PERFO	ELATIVE VALUE GUIDE FOR STHESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA ORMED IN ASSOCIATION WITH AN LE SERVICE 1. HEA	AD
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service	
	Subgroup 1. Head	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service which another item in this Subgroup applies (5 basic units)	to
20100	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units)	
20102	Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units)	1
20104	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units))
20120	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units)	
20124	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on eye, not being a service to which another item in this Group applies (5 basic units))
20140	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (5 basic units)	_
20142	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45 Extended Medicare Safety Net Cap: \$80.40	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units)	
20143	Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (7 basic units)	

-	LE SERVICE	TATION WITH AN 1. HEAD
	Fee: \$140.70	Benefit: 75% = \$105.55 85% = \$119.60
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for vitrectomy (7 basic units)
20145	Fee: \$140.70	Benefit: 75% = \$105.55 85% = \$119.60
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units)
20146	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for squint repair (6 basic units)
20147	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units)
20148	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		management of anaesthesia for intranasal or accessory sinuses, not being a service to tem in this Subgroup applies (6 basic units)
20160	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
	Initiation of the ablation (7 basic	management of anaesthesia for intranasal surgery for malignancy or for intranasal c units)
20162	Fee: \$140.70	Benefit: 75% = \$105.55 85% = \$119.60
		F MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and es (4 basic units)
20164	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, not to which another item in this Subgroup applies (6 basic units)
20170	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units)
20172	Fee: \$140.70	Benefit: 75% = \$105.55 85% = \$119.60
	INITIATION O basic units)	F MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9
20174	Fee: \$180.90	Benefit: 75% = \$135.70 85% = \$153.80
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units)
20176	Fee: \$201.00	Benefit: 75% = \$150.75 85% = \$170.85
		F MANAGEMENT OF ANAESTHESIA for procedures on facial bones, not being a nanother item in this Subgroup applies (5 basic units)
20190	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
		F MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones nathism and extensive facial bone reconstruction) (10 basic units)
20192	Fee: \$201.00	Benefit: 75% = \$150.75 85% = \$170.85

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

		F MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service r item in this Subgroup applies (15 basic units)
20210	Fee: \$301.50	Benefit: 75% = \$226.15 85% = \$256.30
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units)
20212	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units)
20214	Fee: \$180.90	Benefit: 75% = \$135.70 85% = \$153.80
		F MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including ysms or arterio-venous abnormalities (20 basic units)
20216	Fee: \$402.00	Benefit: 75% = \$301.50 85% = \$341.70
	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic
20220	Fee: \$201.00	Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic
20222	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units)
20225	Fee: \$241.20	Benefit: 75% = \$180.90 85% = \$205.05
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery ead or face (12 basic units)
20230	(See para TN.10.2 Fee: \$241.20	28 of explanatory notes to this Category) Benefit: 75% = \$180.90 85% = \$205.05
ANAES ONLY P PERFO	AYABLE FOR A	ARE BENEFITS ARE
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service
		Subgroup 2. Neck
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous k not being a service to which another item in this Subgroup applies (5 basic units)
20300	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
20305		F MANAGEMENT OF ANAESTHESIA for incision and drainage of large haematoma, ellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15

ELIGIB	LE SERVICE	2. NECK
	basic units)	
	Fee: \$301.50 Benefit: 75% = \$226.15 85% = \$256.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on oesoph trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not bei which another item in this Subgroup applies (6 basic units)	
20320	Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi la laryngopharyngectomy or pharyngectomy (10 basic units)	aryngectomy,
20321	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the air and mouth) (8 basic units)	way (excluding nose
20330	Fee: \$160.80 Benefit: 75% = \$120.60 85% = \$136.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major v being a service to which another item in this Subgroup applies (10 basic units)	vessels of neck, not
20350	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of maj basic units)	or vessels of neck (5
20352	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tist involving the neck (12 basic units)	sue flap surgery
20355	(See para TN.10.28 of explanatory notes to this Category) Fee: \$241.20 Benefit: 75% = \$180.90 85% = \$205.05	
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE	3. THORAX
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Anaesthesia Performed In Association With An Eligible Service	Payable For
	Subgroup 3. Thorax	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin tissue of the anterior part of the chest, not being a service to which another item in th (3 basic units)	
20400	Fee: \$60.30 Benefit: 75% = \$45.25 85% = \$51.30	
20401	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units)	

ELIGIB	LE SERVICE	3. TH	ORAX
	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35	
	INITIATION OI basic units)	F MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast	(5
20402	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45	
		F MANAGEMENT OF ANAESTHESIA for removal of breast lump or for breast where axillary node dissection is performed (5 basic units)	
20403	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units)	
20404	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55	
		F MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breaeous flaps (8 basic units)	ast
20405	Fee: \$160.80	Benefit: 75% = \$120.60 85% = \$136.70	
		F MANAGEMENT OF ANAESTHESIA for radical or modified radical procedure nal mammary node dissection (13 basic units)	es on
20406	Fee: \$261.30	Benefit: 75% = \$196.00 85% = \$222.15	
	INITIATION OI basic units)	F MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias	(4
20410	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35	
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaned terior part of the chest not being a service to which another item in this Subgroup a	
20420	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OI sternum (4 basic	F MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy or units)	f the
20440	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35	
		F MANAGEMENT OF ANAESTHESIA for procedures on clavicle, scapula or stoce to which another item in this Subgroup applies (5 basic units)	ernum,
20450	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OI sternum (6 basic	F MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula c units))r
20452	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55	
		F MANAGEMENT OF ANAESTHESIA for partial rib resection, not being a serv em in this Subgroup applies (6 basic units)	ice to
20470	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55	
20472	INITIATION OI	F MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units)	

ANAES	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA
PERFO	RMED IN ASSOCIATION WITH AN
ELIGIBI	
	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
	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) Fee: \$261.30 Benefit: 75% = \$196.00 85% = \$222.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior thorax (10 basic units)
20475	(See para TN.10.28 of explanatory notes to this Category)Fee: $$201.00$ Benefit: $75\% = 150.75 $85\% = 170.85
ONLY F PERFO	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 4. INTRATHORACIO
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 4. Intrathoracic
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15 basic units)
20500	Fee: \$301.50 Benefit: 75% = \$226.15 85% = \$256.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (6 basic units)
20520	Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units)
20522	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
20322	INITIATION OF MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units)
20524	Fee: \$80.40Benefit: 75% = \$60.3085% = \$68.35INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units)
20526	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units)
20528	Fee: \$160.80 Benefit: 75% = \$120.60 85% = \$136.70
20528	Fee: \$160.80Benefit: 75% = \$120.6085% = \$136.70INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this Subgroup applies (13 basic units)

ANAES	ELATIVE VALUE (THESIA - MEDIC) PAYABLE FOR AI	ARE BENEFITS ARE
PERFO	RMED IN ASSOC	IATION WITH AN
ELIGIB		4. INTRATHORAC
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units)
20542	Fee: \$301.50	Benefit: 75% = \$226.15 85% = \$256.30
	INITIATION OF (15 basic units)	F MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty
20546	Fee: \$301.50	Benefit: 75% = \$226.15 85% = \$256.30
	INITIATION OF and bronchi (15	F MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea pasic units)
20548	Fee: \$301.50	Benefit: 75% = \$226.15 85% = \$256.30
	Initiation of the r	nanagement of anaesthesia for:
	(a) open procedu	res on the heart, pericardium or great vessels of the chest; or
	(b) percutaneous	insertion of a valvular prosthesis (20 basic units)
20560	Fee: \$402.00	
ANAES ONLY F PERFO		ARE BENEFITS ARE NAESTHESIA
ANAES ONLY F PERFO	ELATIVE VALUE (THESIA - MEDIC PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 5. SPINE AND SPINAL COP tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
ANAES ONLY F PERFO	ELATIVE VALUE (THESIA - MEDIC PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 5. SPINE AND SPINAL COP
ANAES ONLY F PERFO	ELATIVE VALUE (STHESIA - MEDICA PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe INITIATION OF not being a service	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 5. SPINE AND SPINAL COI tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service
ANAES ONLY F PERFO ELIGIB	ELATIVE VALUE (STHESIA - MEDICA PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe INITIATION OF not being a service	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 5. SPINE AND SPINAL COM Intive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service Subgroup 5. Spine And Spinal Cord 5 MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord ce to which another item in this Subgroup applies (for myelography and discography
ANAES ONLY F PERFO	ELATIVE VALUE (THESIA - MEDICA PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per INITIATION OF not being a servio see Items 21908 Fee: \$201.00 INITIATION OF	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service Subgroup 5. Spine And Spinal Cord F MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord ce to which another item in this Subgroup applies (for myelography and discography and 21914) (10 basic units)
ANAES ONLY F PERFO ELIGIB	ELATIVE VALUE (THESIA - MEDICA PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per INITIATION OF not being a servio see Items 21908 Fee: \$201.00 INITIATION OF	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 5. SPINE AND SPINAL COP trive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service Subgroup 5. Spine And Spinal Cord R MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord ce to which another item in this Subgroup applies (for myelography and discography and 21914) (10 basic units) Benefit: 75% = \$150.75 85% = \$170.85 F MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the
ANAES ONLY F PERFO ELIGIB	ELATIVE VALUE (THESIA - MEDICA PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe INITIATION OF not being a servit see Items 21908 Fee: \$201.00 INITIATION OF patient in the sitt Fee: \$261.30 INITIATION OF	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 5. SPINE AND SPINAL CON ntive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service Subgroup 5. Spine And Spinal Cord R MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord r MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord main 21914) (10 basic units) Benefit: 75% = \$150.75 85% = \$170.85 F MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the ing position (13 basic units)
ANAES ONLY F PERFO ELIGIB	ELATIVE VALUE (THESIA - MEDICA PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe INITIATION OF not being a servit see Items 21908 Fee: \$201.00 INITIATION OF patient in the sitt Fee: \$261.30 INITIATION OF	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 5. SPINE AND SPINAL CON trive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service Subgroup 5. Spine And Spinal Cord F MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord ce to which another item in this Subgroup applies (for myelography and discography and 21914) (10 basic units) Benefit: 75% = \$150.75 85% = \$170.85 F MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the ing position (13 basic units) Benefit: 75% = \$196.00 85% = \$222.15 F MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord
ANAES ONLY F PERFO ELIGIB	ELATIVE VALUE (THESIA - MEDICA PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per INITIATION OF not being a servio see Items 21908 Fee: \$201.00 INITIATION OF patient in the sitt Fee: \$261.30 INITIATION OF not being a servio Fee: \$201.00	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 5. SPINE AND SPINAL CON ntive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service Subgroup 5. Spine And Spinal Cord F MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord re to which another item in this Subgroup applies (for myelography and discography and 21914) (10 basic units) Benefit: 75% = \$150.75 85% = \$170.85 F MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the ing position (13 basic units) Benefit: 75% = \$196.00 85% = \$222.15 F MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord ce to which another item in this Subgroup applies (10 basic units)
ANAES ONLY F PERFO ELIGIB	ELATIVE VALUE (THESIA - MEDICA PAYABLE FOR AI RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe INITIATION OF not being a servional see Items 21908 Fee: \$201.00 INITIATION OF patient in the sitt Fee: \$261.30 INITIATION OF not being a servional Fee: \$201.00 INITIATION OF INITIATION	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN 5. SPINE AND SPINAL CON trive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service Subgroup 5. Spine And Spinal Cord F MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord Total cord Benefit: 75% = \$150.75 BSS% = \$170.85 F MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the ing position (13 basic units) Benefit: 75% = \$150.75 BENEFITS ARE MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the ing position (13 basic units) Benefit: 75% = \$196.00 BS% = \$222.15 F MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord ce to which another item in this Subgroup applies (10 basic units) Benefit: 75% = \$196.00 BENEFIT: 75% = \$196.00 BS% = \$170.85

5. SPINE AND SPINAL CORD

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LATIVE VALUE GUIDE FOR	
THESIA - MEDICARE BENEFITS ARE	
PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN	
LE SERVICE 6. UPPER ABDOME	
involving the anterior or posterior upper abdomen (10 basic units)	
(See para TN.10.28 of explanatory notes to this Category) Fee: $$201.00$ Benefit: $75\% = 150.75 $85\% = 170.85	
Initiation of the management of anaesthesia for laparoscopic procedures in the upper abdomen, including 1000	
laparoscopic cholecystectomy, not being a service to which another item in this Subgroup applies (7 basic units)	
(See para TN.10.27 of explanatory notes to this Category) Fee: \$140.70 Benefit: 75% = \$105.55 85% = \$119.60	
INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units)	
Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures (5 basic units)	
Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
Initiation of the management of anaesthesia for either or both of the following: (a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage; (b) endoscopic retrograde cholangiopancreatography (7 basic units)	
Fee: \$140.70 Benefit: 75% = \$105.55 85% = \$119.60	
Initiation of the management of anaesthesia for hernia repairs to the upper abdominal wall, other than a service to which another item in this Subgroup applies. (5 basic units)	
(See para TN.10.27 of explanatory notes to this Category) Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units)	
Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55	
INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units)	
Fee: \$140.70 Benefit: 75% = \$105.55 85% = \$119.60	
INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units)	
Fee: \$180.90 Benefit: 75% = \$135.70 85% = \$153.80	
INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units)	
Fee: \$301.50 Benefit: 75% = \$226.15 85% = \$256.30	
Initiation of the management of anaesthesia for procedures within the peritoneal cavity in upper abdomen, including any of the following: (a) open cholecystectomy;	

6. UPPER ABDOMEN

	(b) gastrectomy;(c) laparoscopica(d) bowel shunts	ally assisted nephrectomy;
	Fee: \$160.80	Benefit: 75% = \$120.60 85% = \$136.70
	Initiation of the pobesity (10 basic	management of anaesthesia for bariatric surgery in a patient with clinically severe e units)
20791	(See para TN.8.29 Fee: \$201.00	of explanatory notes to this Category) Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OI biopsy) (13 basic	F MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver c units)
20792	Fee: \$261.30	Benefit: 75% = \$196.00 85% = \$222.15
	INITIATION OI basic units)	F MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15
20793	Fee: \$301.50	Benefit: 75% = \$226.15 85% = \$256.30
	INITIATION OI units)	F MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic
20794	Fee: \$241.20	Benefit: 75% = \$180.90 85% = \$205.05
	INITIATION OI upper abdomen (F MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the (10 basic units)
20798	Fee: \$201.00	Benefit: 75% = \$150.75 85% = \$170.85
		F MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra- in the upper abdomen (6 basic units)
20799	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
ANAES ONLY F PERFO	PAYABLE FOR A	ARE BENEFITS ARE
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service
		Subgroup 7. Lower Abdomen
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er anterior abdominal walls, not being a service to which another item in this Subgroup units)
	11 、	
20800	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30

7. LOWER ABDOMEN

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pic procedures (4
ve lithotripsy to
ts derivatives or
odomen, not being
ae and/or wound
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ng laparoscopic basic units)
in this Sul

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

7. LOWER ABDOMEN

	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units)
20842	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for abdominoperineal resection, including put through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units)
20844	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units)
20845	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units)
20846	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units)
20847	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units)
20848	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units)
20850	Fee: \$241.20 Benefit: 75% = \$180.90 85% = \$205.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean hysterectomy or hysterectomy within 24 hours of birth (15 basic units)
20855	Fee: \$301.50 Benefit: 75% = \$226.15 85% = \$256.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgrou applies (6 basic units)
20860	Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units)
20862	Fee: \$140.70 Benefit: 75% = \$105.55 85% = \$119.60
	INITIATION OF MANAGEMENT OF ANAESTHESIA for nephrectomy (10 basic units)
20863	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units)
20864	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units)
20866	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
20867	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units)

	LE SERVICE	CIATION WITH AN	7. LOWER ABDOME
	Fee: \$201.00	Benefit: 75% = \$150.75	85% = \$170.85
	INITIATION C (10 basic units)		AESTHESIA for renal transplantation (donor or recipient)
20868	Fee: \$201.00	Benefit: 75% = \$150.75	85% = \$170.85
			AESTHESIA for procedures on major lower abdominal item in this subgroup applies (15 basic units)
20880	Fee: \$301.50	Benefit: 75% = \$226.15	85% = \$256.30
	INITIATION O	F MANAGEMENT OF ANA	AESTHESIA for inferior vena cava ligation (10 basic units
20882	Fee: \$201.00	Benefit: 75% = \$150.75	85% = \$170.85
	INITIATION O units)	F MANAGEMENT OF ANA	AESTHESIA for percutaneous umbrella insertion (5 basic
20884	Fee: \$100.50	Benefit: 75% = \$75.40	85% = \$85.45
		F MANAGEMENT OF ANA n in the lower abdomen (6 ba	AESTHESIA for percutaneous procedures on an intra- asic units)
20886	Fee: \$120.60	Benefit: 75% = \$90.45	85% = \$102.55
ANAES ONLY F PERFO	PAYABLE FOR A RMED IN ASSO LE SERVICE	CARE BENEFITS ARE NAESTHESIA CIATION WITH AN	8. PERINEU esthesia - Medicare Benefits Are Only Payable For th An Eligible Service
		Su	ubgroup 8. Perineum
			AESTHESIA for procedures on the skin or subcutaneous which another item in this Subgroup applies (3 basic units
20900	Fee: \$60.30	Benefit: 75% = \$45.25	85% = \$51.30
		management of anaesthesia f omy, but not banding of haen	for anorectal procedures (including surgical norrhoids) (4 basic units)
20902	Fee: \$80.40	Benefit: 75% = \$60.30	85% = \$68.35

20902	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		OF MANAGEMENT OF ANAESTHESIA for radical perineal procedures including prostatectomy or radical vulvectomy (7 basic units)
20904	Fee: \$140.70	Benefit: 75% = \$105.55 85% = \$119.60
	INITIATION O	OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery

 (See para TN.10.28 of explanatory notes to this Category)

 20905
 Fee: \$201.00
 Benefit: 75% = \$150.75
 85% = \$170.85

-		GUIDE FOR ARE BENEFITS ARE
ONLY F	AYABLE FOR A	NAESTHESIA
	RMED IN ASSOC LE SERVICE	CIATION WITH AN 8. PERINEUM
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units)
20906	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for transurethral procedures (including by), not being a service to which another item in this Subgroup applies (4 basic units)
20910	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for endoscopic ureteroscopic surgery procedures (5 basic units)
20911	(See para TN.10.2 Fee: \$100.50	9 of explanatory notes to this Category) Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION O tumour(s) (5 bas	F MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder ic units)
20912	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic
20914	Fee: \$140.70	Benefit: 75% = \$105.55 85% = \$119.60
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7
20916	Fee: \$140.70	Benefit: 75% = \$105.55 85% = \$119.60
		agement of anaesthesia for procedures on external genitalia, not being a service to em in this Subgroup applies. (4 basic units)
20920	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, teral (4 basic units)
20924	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (4
20926	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION O (6 basic units)	F MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach
20928	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic
20930	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
20022	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic
20932		

	LE SERVICE	8. PERINEUM
	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for complete amputation of penis with lymphadenectomy (6 basic units)
20934	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
		F MANAGEMENT OF ANAESTHESIA for complete amputation of penis with l and iliac lymphadenectomy (8 basic units)
20936	Fee: \$160.80	Benefit: 75% = \$120.60 85% = \$136.70
	INITIATION Of units)	F MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic
20938	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures y of vagina, cervix or endometrium), not being a service to which another item in this s (4 basic units)
20940	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for vaginal procedures including repair rinary incontinence procedures (perineal) (5 basic units)
20942	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION O (4 basic units)	F MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services
20943	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
20044		F MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units)
20944	Fee: \$120.60	Benefit: $75\% = \$90.45$ $85\% = \$102.55$
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for vaginal birth (8 basic units)
20946	Fee: \$160.80	Benefit: 75% = \$120.60 85% = \$136.70
		F MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal gature (4 basic units)
20948	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units)
20950	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units)
20952	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic
20954	Fee: \$201.00	Benefit: 75% = \$150.75 85% = \$170.85

8. PERINEUM

	INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units)
20956	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for manual removal of retained placenta or for repair of vaginal or perineal tear following birth (5 basic units)
20958	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units)
20960	Fee: \$140.70 Benefit: 75% = \$105.55 85% = \$119.60
ONLY F PERFO	THESIA - MEDICARE BENEFITS ARE PAYABLE 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	Fee: \$60.30 Benefit: 75% = \$45.25 85% = \$51.30
21100	Fee: \$60.30Benefit: 75% = \$45.2585% = \$51.30INITIATION 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)
21100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or
	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)
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units) Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45 INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the
21110	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units) Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45 INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)
21110 21112	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units)Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the
21110	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units) Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45 INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35 INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35 INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)
21110 21112 21114	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units)Fee: \$100.50Benefit: 75% = \$75.4085% = \$85.45INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)Fee: \$80.40Benefit: 75% = \$60.3085% = \$68.35INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)Fee: \$100.50Benefit: 75% = \$75.4085% = \$85.45INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)Fee: \$100.50Benefit: 75% = \$75.4085% = \$85.45INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)Fee: \$100.50Benefit: 75% = \$75.4085% = \$85.45INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting
21110 21112	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units)Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)Fee: \$100.50 Benefit: 75% = \$60.30 85% = \$68.35INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the
21110 21112 21114	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units)Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)Fee: \$100.50 Benefit: 75% = \$60.30 85% = \$68.35INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (6 basic units)Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units)Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic

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

9. PELVIS (EXCEPT HIP)

	performed in the	operating theatre of a hospital (3 basic units)
	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30
	INITIATION OF amputation (15 ba	MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) asic units)
21140	Fee: \$301.50	Benefit: 75% = \$226.15 85% = \$256.30
		MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the d-quarter amputation (10 basic units)
21150	Fee: \$201.00	Benefit: 75% = \$150.75 85% = \$170.85
		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery erior or posterior pelvis (10 basic units)
21155	(See para TN.10.28 Fee: \$201.00	of explanatory notes to this Category) Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for closed procedures involving symphysis c joint when performed in the operating theatre of a hospital (4 basic units)
21160	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis
	pubis or sacroilia	c joint (8 basic units)
	Fee: \$160.80	c joint (8 basic units) Benefit: 75% = \$120.60 85% = \$136.70 GUIDE FOR
T10. RE ANAES ONLY F PERFO	Fee: \$160.80 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Relat	c joint (8 basic units) Benefit: 75% = \$120.60 85% = \$136.70 GUIDE FOR ARE BENEFITS ARE IAESTHESIA ATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
T10. RE ANAES ONLY F PERFO	Fee: \$160.80 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Relat	c joint (8 basic units) Benefit: 75% = \$120.60 85% = \$136.70 GUIDE FOR ARE BENEFITS ARE IAESTHESIA 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
T10. RE ANAES ONLY F PERFO	Fee: \$160.80 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Relat Anaesthesia Per	c joint (8 basic units) Benefit: 75% = \$120.60 85% = \$136.70 GUIDE FOR ARE BENEFITS ARE IAESTHESIA ATION WITH AN 10. UPPER LEG (EXCEPT KNEE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
T10. RE ANAES ONLY F PERFO ELIGIBI	Fee: \$160.80 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Relat Anaesthesia Per	c joint (8 basic units) Benefit: 75% = \$120.60 85% = \$136.70 GUIDE FOR ARE BENEFITS ARE IAESTHESIA 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) MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous
T10. RE ANAES ONLY F PERFO ELIGIBI	Fee: \$160.80 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Relat Anaesthesia Per INITIATION OF tissue of the uppe Fee: \$60.30 INITIATION OF	c joint (8 basic units) Benefit: 75% = \$120.60 85% = \$136.70 GUIDE FOR ARE BENEFITS ARE JAESTHESIA ATION 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) MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous r leg (3 basic units)
21195	Fee: \$160.80 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Relat Anaesthesia Per INITIATION OF tissue of the uppe Fee: \$60.30 INITIATION OF	c joint (8 basic units) Benefit: 75% = \$120.60 85% = \$136.70 GUIDE FOR ARE BENEFITS ARE JAESTHESIA ATION 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) MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous r leg (3 basic units) Benefit: 75% = \$45.25 85% = \$51.30 MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons,
21195	Fee: \$160.80 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Relat Anaesthesia Per INITIATION OF tissue of the uppe Fee: \$60.30 INITIATION OF fascia or bursae o Fee: \$80.40 INITIATION OF	c joint (8 basic units) Benefit: 75% = \$120.60 85% = \$136.70 GUIDE FOR ARE BENEFITS ARE JAESTHESIA ATION 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) MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous r leg (3 basic units) Benefit: 75% = \$45.25 85% = \$51.30 MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, f the upper leg (4 basic units)
T10. RE ANAES ONLY F PERFO	Fee: \$160.80 ELATIVE VALUE G THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOCI LE SERVICE Group T10. Relat Anaesthesia Per INITIATION OF tissue of the uppe Fee: \$60.30 INITIATION OF fascia or bursae o Fee: \$80.40 INITIATION OF	e joint (8 basic units) Benefit: 75% = \$120.60 85% = \$136.70 GUIDE FOR ARE BENEFITS ARE JAESTHESIA 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) MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous r leg (3 basic units) Benefit: 75% = \$45.25 85% = \$51.30 MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, f the upper leg (4 basic units) Benefit: 75% = \$60.30 85% = \$68.35 MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint whe

10. UPPER LEG (EXCEPT KNEE)

	basic units)	
	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for op being a service to which another item in this Subgroup applies (6	
21210	Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for hij	p disarticulation (10 basic units)
21212	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for tot units)	al hip replacement or revision (10 basic
21214	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bil units)	ateral total hip replacement (14 basic
21216	Fee: \$281.40 Benefit: 75% = \$211.05 85% = \$239.20	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for clo femur when performed in the operating theatre of a hospital (4 b	
21220	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for op femur, not being a service to which another item in this Subgrou	
21230	Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for ab	ove knee amputation (5 basic units)
21232	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for rad (8 basic units)	dical resection of the upper 2/3 of femur
21234	Fee: \$160.80 Benefit: 75% = \$120.60 85% = \$136.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pre- including exploration (4 basic units)	ocedures involving veins of upper leg,
21260	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pro- including bypass graft, not being a service to which another item	
21270	Fee: \$160.80 Benefit: 75% = \$120.60 85% = \$136.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for fer	moral artery ligation (4 basic units)
21272	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for fer	moral artery embolectomy (6 basic units)
21274	(See para TN.10.24 of explanatory notes to this Category)	

10. UPPER LEG (EXCEPT KNEE)

	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery er leg (10 basic units)
21275	(See para TN.10.28 Fee: \$201.00	of explanatory notes to this Category) Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF (15 basic units)	MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg
21280	Fee: \$301.50	Benefit: 75% = \$226.15 85% = \$256.30
ANAES ONLY F PERFO	PAYABLE FOR AN RMED IN ASSOCI LE SERVICE	ARE BENEFITS ARE IAESTHESIA ATION WITH AN 11. KNEE AND POPLITEAL ARE/
		tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service
		Subgroup 11. Knee And Popliteal Area
		MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous and/or popliteal area (3 basic units)
21300	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30
		MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, f knee and/or popliteal area (4 basic units)
21321	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		MANAGEMENT OF ANAESTHESIA for closed procedures on lower 1/3 of femur n the operating theatre of a hospital (4 basic units)
21340	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5
21360	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
		MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when operating theatre of a hospital (3 basic units)
21380	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30
	INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4
21382	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
		MANAGEMENT OF ANAESTHESIA for closed procedures on upper ends of tibia, ella when performed in the operating theatre of a hospital (3 basic units)

11. KNEE AND POPLITEAL AREA

	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30		
		F MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, tella (4 basic units)		
21392	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not being a service to which another item in this Subgroup applies (4 basic units)			
21400	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35		
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units)		
21402	Fee: \$140.70	Benefit: 75% = \$105.55 85% = \$119.60		
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units)		
21403	Fee: \$201.00	Benefit: 75% = \$150.75 85% = \$170.85		
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units)		
21404	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair involving knee joint, undertaken in a hospital (3 basic units)			
21420	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of knee or popliteal area, not being a service to which another item in this Subgroup applies (4 basic units)			
21430	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or popliteal area (5 basic units)			
21432	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of knee or popliteal area, not being a service to which another item in this Subgroup applies (8 basic units)			
21440	Fee: \$160.80	Benefit: 75% = \$120.60 85% = \$136.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the knee and/or popliteal area (10 basic units)			
21445	(See para TN.10.2 Fee: \$201.00	28 of explanatory notes to this Category) Benefit: 75% = \$150.75 85% = \$170.85		
ANAEST ONLY P PERFOF	AYABLE FOR A RMED IN ASSOC	ARE BENEFITS ARE NAESTHESIA CIATION WITH AN		
ELIGIBL		12. LOWER LEG (BELOW KNEE ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service		

12. LOWER LEG (BELOW KNEE)

		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: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30		
		F MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, or eg, ankle, or foot, not being a service to which another item in this Subgroup applies (4		
21461	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35		
	INITIATION OF foot (3 basic unit	F MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or s)		
21462	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30		
	INITIATION OF basic units)	F MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4		
21464	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35		
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units)		
21472	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45		
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units)		
21474	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45		
		F MANAGEMENT OF ANAESTHESIA for open procedures on bones of lower leg, cluding amputation, not being a service to which another item in this Subgroup applies		
21480	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower leg, ankle or foot (5 basic units)			
21482	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45		
	INITIATION OF (5 basic units)	F MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula		
21484	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units)			
21486	Fee: \$140.70	Benefit: 75% = \$105.55 85% = \$119.60		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or repair, undertaken in a hospital (3 basic units)			
21490	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30		
21500	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for procedures on arteries of lower leg,		

ANAES ONLY F	ELATIVE VALUE STHESIA - MEDIC PAYABLE FOR A RMED IN ASSOC	ARE BENEFITS ARE IAESTHESIA			
	LE SERVICE	12. LOWER LEG (BELOW KNE	EE)		
	including bypas	graft, not being a service to which another item in this Subgroup applies (8 basic unit	ts)		
	Fee: \$160.80	Benefit: 75% = \$120.60 85% = \$136.70			
	INITIATION O units)	MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic			
21502	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55			
		MANAGEMENT OF ANAESTHESIA for procedures on veins of lower leg, not which another item in this Subgroup applies (4 basic units)			
21520	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35			
	INITIATION O basic units)	MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5		
21522	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45			
		INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg, ankle or foot (15 basic units)			
21530	Fee: \$301.50	Benefit: 75% = \$226.15 85% = \$256.30			
	INITIATION O basic units)	MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8			
21532	Fee: \$160.80	Benefit: 75% = \$120.60 85% = \$136.70			
		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery er leg (10 basic units)			
21535	(See para TN.10.2 Fee: \$201.00	of explanatory notes to this Category) Benefit: 75% = \$150.75 85% = \$170.85			
ANAES ONLY F PERFO	ELATIVE VALUE STHESIA - MEDIC PAYABLE FOR A RMED IN ASSOC LE SERVICE	ARE BENEFITS ARE IAESTHESIA	LA		
		tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service			
		Subgroup 13. Shoulder And Axilla			
		INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)			
21600	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30			
		MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, f shoulder or axilla including axillary dissection (5 basic units)			
	-				

 21610
 Fee: \$100.50
 Benefit: 75% = \$75.40
 85% = \$85.45

13. SHOULDER AND AXILLA

ELIGIBI	LIGIBLE SERVICE 13. SHOULDER AND AXIL			
	neck, sternoclavic theatre of a hospit	cular joint, acromioclavicular joint, or shoulder joint when performed in the operating tal (4 basic units)		
	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35		
	INITIATION OF (5 basic units)	MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint		
21622	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45		
	neck, sternoclavic	MANAGEMENT OF ANAESTHESIA for open procedures on humeral head and cular joint, acromioclavicular joint or shoulder joint, not being a service to which is Subgroup applies (5 basic units)		
21630	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45		
		MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head lavicular joint, acromioclavicular joint or shoulder joint (6 basic units)		
21632	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55		
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units)		
21634	Fee: \$180.90	Benefit: 75% = \$135.70 85% = \$153.80		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) amputation (15 basic units)			
21636	Fee: \$301.50	Benefit: 75% = \$226.15 85% = \$256.30		
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units)		
21638	Fee: \$201.00	Benefit: 75% = \$150.75 85% = \$170.85		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of shoulder or axilla, not being a service to which another item in this Subgroup applies (8 basic units)			
21650	Fee: \$160.80	Benefit: 75% = \$120.60 85% = \$136.70		
	INITIATION OF (10 basic units)	MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm		
21652	Fee: \$201.00	Benefit: 75% = \$150.75 85% = \$170.85		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or axilla (8 basic units)			
21654	Fee: \$160.80	Benefit: 75% = \$120.60 85% = \$136.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic units)			
21656	Fee: \$201.00	Benefit: 75% = \$150.75 85% = \$170.85		
	INITIATION OF (4 basic units)	MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla		
21670	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35		

	LATIVE VALUE THESIA - MEDIC	GUIDE FOR ARE BENEFITS ARE	
	AYABLE FOR A		
	RMED IN ASSOC LE SERVICE	CIATION WITH AN	13. SHOULDER AND AXILLA
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for a service to which another item in this Subg	shoulder cast application, removal or
21680	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30	
		F MANAGEMENT OF ANAESTHESIA for hospital (4 basic units)	shoulder spica application when
21682	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35	
		F MANAGEMENT OF ANAESTHESIA for oulder or the axilla (10 basic units)	microvascular free tissue flap surgery
21685	(See para TN.10.2 Fee: \$201.00	8 of explanatory notes to this Category) Benefit: 75% = \$150.75 85% = \$170.85	
	LE SERVICE Group T10. Rela	CIATION WITH AN	
	Anaesthesia Pe	rformed In Association With An Eligible S	ervice
		Subgroup 14. Upper Arm	And Elbow
		F MANAGEMENT OF ANAESTHESIA for er arm or elbow (3 basic units)	procedures on the skin or subcutaneous
21700	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30	
		F MANAGEMENT OF ANAESTHESIA for of upper arm or elbow, not being a service to units)	•
21710	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35	
	INITIATION OI (5 basic units)	F MANAGEMENT OF ANAESTHESIA for	open tenotomy of the upper arm or elbow
21712	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for	tenoplasty of the upper arm or elbow (5
21714	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION Of biceps (5 basic u	F MANAGEMENT OF ANAESTHESIA for inits)	tenodesis for rupture of long tendon of
21716	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45	
21730	INITIATION O	F MANAGEMENT OF ANAESTHESIA for	closed procedures on the upper arm

14. UPPER ARM AND ELBOW

			14. OFFER ARM AND LEDOW
	or elbow when	performed in the operating the	heatre of a hospital (3 basic units)
	Fee: \$60.30	Benefit: 75% = \$45.25	85% = \$51.30
	INITIATION Of basic units)	F MANAGEMENT OF ANA	AESTHESIA for arthroscopic procedures of elbow joint (4
21732	Fee: \$80.40	Benefit: 75% = \$60.30	85% = \$68.35
			AESTHESIA for open procedures on the upper arm or item in this Subgroup applies (5 basic units)
21740	Fee: \$100.50	Benefit: 75% = \$75.40	85% = \$85.45
	INITIATION OF elbow (6 basic u		AESTHESIA for radical procedures on the upper arm or
21756	Fee: \$120.60	Benefit: 75% = \$90.45	85% = \$102.55
	INITIATION O	F MANAGEMENT OF ANA	AESTHESIA for total elbow replacement (7 basic units)
21760	Fee: \$140.70	Benefit: 75% = \$105.55	85% = \$119.60
			AESTHESIA for procedures on arteries of upper arm, not Subgroup applies (8 basic units)
21770	Fee: \$160.80	Benefit: 75% = \$120.60	85% = \$136.70
	INITIATION O (6 basic units)	F MANAGEMENT OF ANA	AESTHESIA for embolectomy of arteries of the upper arm
21772	Fee: \$120.60	Benefit: 75% = \$90.45	85% = \$102.55
	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	Fee: \$80.40	Benefit: 75% = \$60.30	85% = \$68.35
		F MANAGEMENT OF ANA per arm or elbow (10 basic u	AESTHESIA for microvascular free tissue flap surgery inits)
21785	(See para TN.10.2 Fee: \$201.00	8 of explanatory notes to this C Benefit: 75% = \$150.75	
	INITIATION OF (15 basic units)	F MANAGEMENT OF ANA	AESTHESIA for microsurgical reimplantation of upper arm
21790	Fee: \$301.50	Benefit: 75% = \$226.15	85% = \$256.30
ANAES ONLY P PERFOI	AYABLE FOR A	ARE BENEFITS ARE	15. FOREARM WRIST AND HAND
		ative Value Guide For Anae rformed In Association Wi	esthesia - Medicare Benefits Are Only Payable For th An Eligible Service

15. FOREARM WRIST AND HAND

	Subgroup 15. Forearm Wrist And Hand
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units)
21800	Fee: \$60.30 Benefit: 75% = \$45.25 85% = \$51.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (4 basic units)
21810	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital (3 basic units)
21820	Fee: \$60.30 Benefit: 75% = \$45.25 85% = \$51.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this Subgroup applies (4 basic units)
21830	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units)
21832	Fee: \$140.70 Benefit: 75% = \$105.55 85% = \$119.60
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint (4 basic units)
21834	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units)
21840	Fee: \$160.80 Benefit: 75% = \$120.60 85% = \$136.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units)
21842	Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units)
21850	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, removal, or repair when rendered to a patient as part of an episode of hospital treatment (3 basic units)
21860	Fee: \$60.30 Benefit: 75% = \$45.25 85% = \$51.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units)
21865	(See para TN.10.28 of explanatory notes to this Category) Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85
21870	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm,

ANAES	T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA		
	RMED IN ASSOC	IATION WITH AN	15. FOREARM WRIST AND HAND
	wrist or hand (15	basic units)	
	Fee: \$301.50	Benefit: 75% = \$226.15	85% = \$256.30
	INITIATION OI basic units)	F MANAGEMENT OF AN	AESTHESIA for microsurgical reimplantation of a finger (8
21872	Fee: \$160.80	Benefit: 75% = \$120.60	85% = \$136.70
ANAES ONLY F PERFO	PAYABLE FOR A	ARE BENEFITS ARE	16. ANAESTHESIA FOR BURNS
		ative Value Guide For Ana rformed In Association Wi	esthesia - Medicare Benefits Are Only Payable For th An Eligible Service
		Subgrou	o 16. Anaesthesia For Burns
			AESTHESIA for excision or debridement of burns, with or involves not more than 3% of total body surface (3 basic
21878	Fee: \$60.30	Benefit: 75% = \$45.25	85% = \$51.30
	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: \$100.50	Benefit: 75% = \$75.40	85% = \$85.45
		ting, where the area of burr	AESTHESIA for excision or debridement of burns, with or involves 10% or more but less than 20% of total body
21880	Fee: \$140.70	Benefit: 75% = \$105.55	85% = \$119.60
		ting, where the area of burr	AESTHESIA for excision or debridement of burns, with or involves 20% or more but less than 30% of total body
21881	Fee: \$180.90	Benefit: 75% = \$135.70	85% = \$153.80
		ting, where the area of burr	AESTHESIA for excision or debridement of burns, with or involves 30% or more but less than 40% of total body
21882	Fee: \$221.10	Benefit: 75% = \$165.85	85% = \$187.95
		ting, where the area of burr	AESTHESIA for excision or debridement of burns, with or involves 40% or more but less than 50% of total body
21883	Fee: \$261.30	Benefit: 75% = \$196.00	85% = \$222.15

ANAES ONLY F PERFO	ELATIVE VALUE (THESIA - MEDIC/ PAYABLE FOR AN RMED IN ASSOC LE SERVICE	ARE BENEFITS ARE NAESTHESIA	16. ANAESTHESIA FOR BURNS
		ting, where the area of burn	AESTHESIA for excision or debridement of burns, with or involves 50% or more but less than 60% of total body
21884	Fee: \$301.50	Benefit: 75% = \$226.15	85% = \$256.30
		ting, where the area of burn	AESTHESIA for excision or debridement of burns, with or involves 60% or more but less than 70% of total body
21885	Fee: \$341.70	Benefit: 75% = \$256.30	85% = \$290.45
		ting, where the area of burn	AESTHESIA for excision or debridement of burns, with or involves 70% or more but less than 80% of total body
21886	Fee: \$381.90	Benefit: 75% = \$286.45	85% = \$324.65
			AESTHESIA for excision or debridement of burns, with or involves 80% or more of total body surface (21 basic units)
1			
ANAES		ARE BENEFITS ARE	
T10. RE ANAES ONLY F PERFO		GUIDE FOR ARE BENEFITS ARE NAESTHESIA	85% = \$358.80 17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
T10. RE ANAES ONLY F PERFO	ELATIVE VALUE (THESIA - MEDIC) PAYABLE FOR AN RMED IN ASSOC LE SERVICE	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES esthesia - Medicare Benefits Are Only Payable For
T10. RE ANAES ONLY F PERFO	ELATIVE VALUE (THESIA - MEDIC/ PAYABLE FOR AN RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN tive Value Guide For Anae formed In Association Wit	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES esthesia - Medicare Benefits Are Only Payable For
T10. RE ANAES ONLY F PERFO	ELATIVE VALUE O THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per Subgroup	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN tive Value Guide For Anae formed In Association Wit	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES esthesia - Medicare Benefits Are Only Payable For th An Eligible Service
T10. RE ANAES ONLY F PERFO	ELATIVE VALUE O THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per Subgroup	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN tive Value Guide For Anae formed In Association Wit o 17. Anaesthesia For Radio	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES esthesia - Medicare Benefits Are Only Payable For th An Eligible Service logical Or Other Diagnostic Or Therapeutic Procedures AESTHESIA for injection procedure for
T10. RE ANAES ONLY F PERFO ELIGIBI	LATIVE VALUE O THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per Subgroup INITIATION OF hysterosalpingog Fee: \$60.30	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN tive Value Guide For Anae formed In Association Wit o 17. Anaesthesia For Radio 7 MANAGEMENT OF ANA raphy (3 basic units) Benefit: 75% = \$45.25	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES esthesia - Medicare Benefits Are Only Payable For th An Eligible Service logical Or Other Diagnostic Or Therapeutic Procedures AESTHESIA for injection procedure for
T10. RE ANAES ONLY F PERFO ELIGIBI	ELATIVE VALUE O THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per Subgroup INITIATION OF hysterosalpingog Fee: \$60.30 INITIATION OF	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN tive Value Guide For Anae formed In Association Wit o 17. Anaesthesia For Radio 7 MANAGEMENT OF ANA raphy (3 basic units) Benefit: 75% = \$45.25	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES esthesia - Medicare Benefits Are Only Payable For th An Eligible Service Mogical Or Other Diagnostic Or Therapeutic Procedures AESTHESIA for injection procedure for 85% = \$51.30 AESTHESIA for injection procedure for myelography:
T10. RE ANAES ONLY F PERFO ELIGIBI	ELATIVE VALUE O THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per Subgroup INITIATION OF hysterosalpingog Fee: \$60.30 INITIATION OF lumbar or thoraci Fee: \$100.50	GUIDE FOR ARE BENEFITS ARE VAESTHESIA IATION WITH AN tive Value Guide For Anae formed In Association Wit to 17. Anaesthesia For Radio 7 MANAGEMENT OF ANA raphy (3 basic units) Benefit: 75% = \$45.25 7 MANAGEMENT OF ANA c (5 basic units) Benefit: 75% = \$75.40 7 MANAGEMENT OF ANA	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES esthesia - Medicare Benefits Are Only Payable For th An Eligible Service Mogical Or Other Diagnostic Or Therapeutic Procedures AESTHESIA for injection procedure for 85% = \$51.30 AESTHESIA for injection procedure for myelography:
T10. RE ANAES ONLY F PERFO ELIGIBI	LATIVE VALUE O THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per Subgroup INITIATION OF hysterosalpingog Fee: \$60.30 INITIATION OF lumbar or thoraci Fee: \$100.50 INITIATION OF	GUIDE FOR ARE BENEFITS ARE VAESTHESIA IATION WITH AN tive Value Guide For Anae formed In Association Wit to 17. Anaesthesia For Radio 7 MANAGEMENT OF ANA raphy (3 basic units) Benefit: 75% = \$45.25 7 MANAGEMENT OF ANA c (5 basic units) Benefit: 75% = \$75.40 7 MANAGEMENT OF ANA	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES esthesia - Medicare Benefits Are Only Payable For th An Eligible Service logical Or Other Diagnostic Or Therapeutic Procedures AESTHESIA for injection procedure for 85% = \$51.30 AESTHESIA for injection procedure for myelography: 85% = \$85.45 AESTHESIA for injection procedure for myelography:
T10. RE ANAES ONLY F PERFO ELIGIBI 21900 21906	ELATIVE VALUE O THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per Subgroup INITIATION OF hysterosalpingog Fee: \$60.30 INITIATION OF lumbar or thoraci Fee: \$100.50 INITIATION OF cervical (6 basic Fee: \$120.60	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN tive Value Guide For Anae formed In Association Wit o 17. Anaesthesia For Radio 7 MANAGEMENT OF ANA raphy (3 basic units) Benefit: 75% = \$45.25 7 MANAGEMENT OF ANA c (5 basic units) Benefit: 75% = \$75.40 7 MANAGEMENT OF ANA units) Benefit: 75% = \$90.45	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES esthesia - Medicare Benefits Are Only Payable For th An Eligible Service logical Or Other Diagnostic Or Therapeutic Procedures AESTHESIA for injection procedure for 85% = \$51.30 AESTHESIA for injection procedure for myelography: 85% = \$85.45 AESTHESIA for injection procedure for myelography:
T10. RE ANAES ONLY F PERFO ELIGIBI 21900 21906	ELATIVE VALUE O THESIA - MEDIC/ PAYABLE FOR AN RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Per Subgroup INITIATION OF hysterosalpingog Fee: \$60.30 INITIATION OF lumbar or thoraci Fee: \$100.50 INITIATION OF cervical (6 basic Fee: \$120.60 INITIATION OF	GUIDE FOR ARE BENEFITS ARE NAESTHESIA IATION WITH AN tive Value Guide For Anae formed In Association Wit o 17. Anaesthesia For Radio 7 MANAGEMENT OF ANA raphy (3 basic units) Benefit: 75% = \$45.25 7 MANAGEMENT OF ANA c (5 basic units) Benefit: 75% = \$75.40 7 MANAGEMENT OF ANA units) Benefit: 75% = \$90.45	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES esthesia - Medicare Benefits Are Only Payable For th An Eligible Service Iogical Or Other Diagnostic Or Therapeutic Procedures AESTHESIA for injection procedure for 85% = \$51.30 AESTHESIA for injection procedure for myelography: 85% = \$85.45 AESTHESIA for injection procedure for myelography: 85% = \$102.55 AESTHESIA for injection procedure for myelography:

17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

		FROGEDORES
	lumbar or thoraci	ic (5 basic units)
	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION OF cervical (6 basic	³ MANAGEMENT OF ANAESTHESIA for injection procedure for discography: units)
21914	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units)
21915	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION OF (5 basic units)	F MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral
21916	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION OF (5 basic units)	F MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral
21918	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
		F MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, nee scanning, digital subtraction angiography scanning (6 basic units)
21922	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
		F MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde retrograde cystourethrography (4 basic units)
21925	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for fluoroscopy (4 basic units)
21926	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units)
21930	Fee: \$120.60	Benefit: 75% = \$90.45 85% = \$102.55
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units)
21935	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
		F MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time examination (5 basic units)
21936	(See para TN.10.26 Fee: \$100.50	6 of explanatory notes to this Category) Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic
21939	Fee: \$60.30	Benefit: 75% = \$45.25 85% = \$51.30
21941		F MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary ntriculography, cardiac mapping, insertion of automatic defibrillator or transvenous

17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

	pacemaker (7 basic units)	
	(See para TN.10.25 of explanatory notes to this Category)	
	Fee: \$140.70 Benefit: 75% = \$105.55 85% = \$119.60	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures including radio frequency ablation (10 basic units)	
21942	Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (5 basic units)	
21943	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or epidural injection (5 basic units)	
21945	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose of transplantation (5 basic units)	
21949	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia (4 basic units)	
21952	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units)	
21955	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5 basic units)	
21959	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units)	
21962	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA as a therapeutic procedure if there is a clinica need for anaesthesia, not for headache of any etiology (5 basic units)	
21965	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units)	
21969	Fee: \$160.80 Benefit: 75% = \$120.60 85% = \$136.70	
	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)	

17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

ELIGIB	LE SERVICE	PROCEDURE
	Fee: \$301.50	Benefit: 75% = \$226.15 85% = \$256.30
		MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed
	sources (5 basic	nits)
21973	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic
21976	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units)
21980	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
ANAES ONLY F PERFO	ELATIVE VALUE (THESIA - MEDIC, PAYABLE FOR AI RMED IN ASSOC LE SERVICE	RE BENEFITS ARE AESTHESIA
		ive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed 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 Fee: \$60.30	of explanatory notes to this Category) Benefit: 75% = \$45.25 85% = \$51.30
		MANAGEMENT OF ANAESTHESIA performed on a person under the age of 10 on with a procedure covered by an item which has not been identified as attracting an ic units)
21992	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
	item that does no	MANAGEMENT OF ANAESTHESIA in connection with a procedure covered by an include the word "(Anaes.)", other than a service to which item 21965 or 21992 a clinical need for anaesthesia (4 basic units)
	(See para TN.10.1)	of explanatory notes to this Category)
21997	Fee: \$80.40	Benefit: 75% = \$60.30 85% = \$68.35
ANAES ONLY F PERFO	ELATIVE VALUE (THESIA - MEDIC, PAYABLE FOR AI RMED IN ASSOC LE SERVICE	RE BENEFITS ARE AESTHESIA
	Group T10. Rela	ive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service

Subgroup 19. Therapeutic And Diagnostic Services

19. THERAPEUTIC AND DIAGNOSTIC SERVICES

	-E SERVICE 19. THERAPEUTIC AND DIAGNOSTIC SERVICES
	Administration of homologous blood or bone marrow already collected, when performed in association with the management of anaesthesia (4 basic units)
22002	(See para TN.10.8 of explanatory notes to this Category)Fee: $\$80.40$ Benefit: $75\% = \$60.30$ $85\% = \$68.35$
	ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units)
22007	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units)
22008	Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient: (a) when performed in association with the management of anaesthesia for the patient; and (b) other than a service to which item 13876 applies (c) is categorised as having a high risk of complications or during the procedure develops either complications or a high risk of complications (3 basic units)
22012	(See para TN.10.8 of explanatory notes to this Category)Fee: $$60.30$ Benefit: $75\% = 45.25 $85\% = 51.30
	 Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient: (a) when performed in association with the management of anaesthesia for the patient; and (b) relating to another discrete operation on the same day for the patient; and (c) other than a service to which item 13876 applies (d) who is categorised as having a high risk of complications or develops during the current procedure either complications or a high risk of complications (3 basic units)
22014	(See para TN.10.8 of explanatory notes to this Category) Fee: 60.30 Benefit: $75\% = 45.25 $85\% = 51.30
	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the administration of anaesthesia (6 basic units)
22015	(See para TN.10.8 of explanatory notes to this Category)Fee: \$120.60Benefit: $75\% = 90.45 $85\% = 102.55
	CENTRAL VEIN CATHETERISATION by percutaneous or open exposure, not being a service to which item 13318 applies, when performed in association with the administration of anaesthesia (4 basic units)
22020	(See para TN.1.6, TN.10.8 of explanatory notes to this Category) Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
22025	Intra-arterial cannulation when performed in association with the management of anaesthesia in a patient who: (a) is categorised as having a high risk of complications; or (b) develops a high risk of complications during the procedure (4 basic units)

19. THERAPEUTIC AND DIAGNOSTIC SERVICES

ELIGIBL	E SERVICE 19. THERAPEUTIC AND DIAGNOSTIC SERVICES
	(See para TN.10.8 of explanatory notes to this Category)Fee: $\$80.40$ Benefit: $75\% = \$60.30$ $85\% = \$68.35$
	Intrathecal or epidural injection (initial) of a therapeutic substance or substances, with or without insertion of a catheter, in association with anaesthesia and surgery, for post-operative pain management, not being a service to which 22036 applies (5 basic units)
22031	(See para TN.10.17 of explanatory notes to this Category) Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45
	INTRATHECAL or EPIDURAL INJECTION (subsequent) of a therapeutic substance or substances, using an in-situ catheter, in association with anaesthesia and surgery, for postoperative pain management, not being a service associated with a service to which 22031 applies (3 basic units)
22036	(See para TN.10.17 of explanatory notes to this Category) Fee: \$60.30 Benefit: 75% = \$45.25 85% = \$51.30
	Perioperative introduction of a plexus or nerve block proximal to the lower leg or forearm for post operative pain management (2 basic units)
22041	(See para TN.10.17 of explanatory notes to this Category) Fee: \$40.20 Benefit: 75% = \$30.15 85% = \$34.20
	Introduction of a nerve block performed via a retrobulbar, peribulbar, or sub Tenon's approach, or other complex eye block, when administered by an anaesthetist perioperatively (1 basic units)
22042	(See para TN.10.8 of explanatory notes to this Category)Fee: $$20.10$ Benefit: $75\% = 15.10 $85\% = 17.10
	INTRA-OPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY - Monitoring in real time of the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or 21936) (9 basic units)
22051	(See para TN.10.30 of explanatory notes to this Category) Fee: \$180.90 Benefit: 75% = \$135.70 85% = \$153.80
	PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units)
22055	(See para TN.10.10 of explanatory notes to this Category) Fee: \$241.20 Benefit: 75% = \$180.90 85% = \$205.05
	WHOLE BODY PERFUSION, CARDIAC BYPASS, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) (20 basic units)
22060	(See para TN.10.10, TN.10.3 of explanatory notes to this Category) Fee: \$402.00 Benefit: 75% = \$301.50 85% = \$341.70
	INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)
22065	(See para TN.10.10 of explanatory notes to this Category) Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45
22075	DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including

ANAESTI ONLY PA	ATIVE VALUE GUIDE FOR HESIA - MEDICARE BENEFITS ARE YABLE FOR ANAESTHESIA
	MED IN ASSOCIATION WITH AN E SERVICE 19. THERAPEUTIC AND DIAGNOSTIC SERVICES
	management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)
	(See para TN.10.10 of explanatory notes to this Category) Fee: \$301.50 Benefit: 75% = \$226.15 85% = \$256.30
ANAESTI	ATIVE VALUE GUIDE FOR HESIA - MEDICARE BENEFITS ARE YABLE FOR ANAESTHESIA
PERFOR	MED IN ASSOCIATION WITH AN E SERVICE20. ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 20. Administration Of Anaesthesia In Connection With A Dental Service
	INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units)
22900	(See para TN.10.14 of explanatory notes to this Category) Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units)
22905	(See para TN.10.14 of explanatory notes to this Category) Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55
ANAESTI ONLY PA PERFORI	ATIVE VALUE GUIDE FOR HESIA - MEDICARE BENEFITS ARE YABLE FOR ANAESTHESIA MED IN ASSOCIATION WITH AN E SERVICE 21. ANAESTHESIA/PERFUSION TIME UNITS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 21. Anaesthesia/Perfusion Time Units
	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA
	(a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or
	(b) perfusion performed in association with item 22060; or
	(c) for assistance at anaesthesia performed in association with items 25200 to 25205
	For a period of:
23010	

21. ANAESTHESIA/PERFUSION TIME UNITS

(FIFTEEN MINUTES OR LESS) (1 basic units)	
(See para TN.10.3 of explanatory notes to this Category) Benefit: $75\% = 15.10 $85\% = 17.10	
16 MINUTES TO 30 MINUTES (2 basic units)	
Fee: \$40.20 Benefit: 75% = \$30.15 85% = \$34.20	
31 MINUTES to 45 MINUTES (3 basic units)	
Fee: \$60.30 Benefit: 75% = \$45.25 85% = \$51.30	
46 MINUTES to 1:00 HOUR (4 basic units)	
Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35	
1:01 HOURS to 1:15 HOURS (5 basic units)	
Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45	
1:16 HOURS to 1:30 HOURS (6 basic units)	
Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55	
1:31 HOURS to 1:45 HOURS (7 basic units)	
Fee: \$140.70 Benefit: 75% = \$105.55 85% = \$119.60	
1:46 HOURS to 2:00 HOURS (8 basic units)	
Fee: \$160.80 Benefit: 75% = \$120.60 85% = \$136.70	
2:01 HOURS TO 2:10 HOURS (9 basic units)	
Fee: \$180.90 Benefit: 75% = \$135.70 85% = \$153.80	
2:11 HOURS TO 2:20 HOURS (10 basic units)	
Fee: \$201.00 Benefit: 75% = \$150.75 85% = \$170.85	
2:21 HOURS TO 2:30 HOURS (11 basic units)	
Fee: \$221.10 Benefit: 75% = \$165.85 85% = \$187.95	
2:31 HOURS TO 2:40 HOURS (12 basic units)	
Fee: \$241.20 Benefit: 75% = \$180.90 85% = \$205.05	
2:41 HOURS TO 2:50 HOURS (13 basic units)	
Fee: \$261.30 Benefit: 75% = \$196.00 85% = \$222.15	
2:51 HOURS TO 3:00 HOURS (14 basic units)	
Fee: \$281.40 Benefit: 75% = \$211.05 85% = \$239.20	
3:01 HOURS TO 3:10 HOURS (15 basic units)	
Fee: \$301.50 Benefit: 75% = \$226.15 85% = \$256.30	

T10. RE		GUIDE FOR	
ANAES	THESIA - MEDIC	ARE BENEFITS ARE	
•••••	AYABLE FOR A	NAESTHESIA IATION WITH AN	
	E SERVICE		21. ANAESTHESIA/PERFUSION TIME UNITS
	3:11 HOURS TO	3:20 HOURS (16 basic units	s)
23116	Fee: \$321.60	Benefit: 75% = \$241.20	85% = \$273.40
	3:21 HOURS TO	3:30 HOURS (17 basic units	s)
23117	Fee: \$341.70	Benefit: 75% = \$256.30	85% = \$290.45
	3:31 HOURS TO	3:40 HOURS (18 basic units	s)
23118	Fee: \$361.80	Benefit: 75% = \$271.35	85% = \$307.55
	3:41 HOURS TO	3:50 HOURS (19 basic units	s)
23119	Fee: \$381.90	Benefit: 75% = \$286.45	85% = \$324.65
	3:51 HOURS TO	0 4:00 HOURS (20 basic units	
23121	Fee: \$402.00	Benefit: 75% = \$301.50	85% = \$341.70
		0 4:10 HOURS (21 basic units	
23170	Fee: \$422.10	Benefit: 75% = \$316.60	85% = \$358.80
20170		0 4:20 HOURS (22 basic units	
23180	Fee: \$442.20	Benefit: 75% = \$331.65	85% - \$375.90
23100		0 4:30 HOURS (23 basic units	
23190	Fee: \$462.30	Benefit: 75% = \$346.75	85% - \$393.00
23170		0 4:40 HOURS (24 basic units	
23200	Fee: \$482.40	Benefit: 75% = \$361.80	, ,
23200		34:50 HOURS (25 basic units)	
22210		× ×	,
23210	Fee: \$502.50	Benefit: 75% = \$376.90 0 5:00 HOURS (26 basic units	
22220			, ,
23220	Fee: \$522.60	Benefit: 75% = \$391.95 0 5:10 HOURS (27 basic units	
			, ,
23230	Fee: \$542.70	Benefit: $75\% = 407.05	
222	5:11 HOURS TO 5:20 HOURS (28 basic units)		
23240	Fee: \$562.80	Benefit: 75% = \$422.10	
		5:30 HOURS (29 basic units	
23250	Fee: \$582.90	Benefit: 75% = \$437.20	
	5:31 HOURS TO 5:40 HOURS (30 basic units)		
23260	Fee: \$603.00	Benefit: 75% = \$452.25	85% = \$518.30

T10. RE		GUIDE FOR	
ANAES	THESIA - MEDIC	ARE BENEFITS ARE	
	PAYABLE FOR A	NAESTHESIA CIATION WITH AN	
	LE SERVICE		21. ANAESTHESIA/PERFUSION TIME UNITS
	5:41 HOURS TO	O 5:50 HOURS (31 basic uni	ts)
23270	Fee: \$623.10	Benefit: 75% = \$467.35	85% = \$538.40
	(5:51 HOURS T	O 6:00 HOURS (32 basic un	
23280	Fee: \$643.20	Benefit: 75% = \$482.40	85% - \$558 50
23200		O 6:10 HOURS (33 basic unit)	
22200		× ×	
23290	Fee: \$663.30	Benefit: 75% = \$497.50 D 6:20 HOURS (34 basic uni	
	0.11 HOUKS IV	J 0.20 HOOKS (54 Dasic ulli	(5)
23300	Fee: \$683.40	Benefit: 75% = \$512.55	
	6:21 HOURS TO	O 6:30 HOURS (35 basic uni	ts)
23310	Fee: \$703.50	Benefit: 75% = \$527.65	85% = \$618.80
	6:31 HOURS TO	O 6:40 HOURS (36 basic uni	ts)
23320	Fee: \$723.60	Benefit: 75% = \$542.70	85% = \$638.90
	6:41 HOURS TO	O 6:50 HOURS (37 basic uni	ts)
23330	Fee: \$743.70	Benefit: 75% = \$557.80	85% = \$659.00
	6:51 HOURS TO	O 7:00 HOURS (38 basic uni	ts)
23340	Fee: \$763.80	Benefit: 75% = \$572.85	85% - \$679.10
23340		O 7:10 HOURS (39 basic uni	
		,	
23350	Fee: \$783.90	Benefit: 75% = \$587.95	
	/:11 HOUKS IV	O 7:20 HOURS (40 basic uni	(5)
23360	Fee: \$804.00	Benefit: 75% = \$603.00	
	7:21 HOURS TO	O 7:30 HOURS (41 basic uni	ts)
23370	Fee: \$824.10	Benefit: 75% = \$618.10	85% = \$739.40
	7:31 HOURS TO	O 7:40 HOURS (42 basic uni	ts)
23380	Fee: \$844.20	Benefit: 75% = \$633.15	85% = \$759.50
	7:41 HOURS TO	O 7:50 HOURS (43 basic uni	ts)
23390	Fee: \$864.30	Benefit: 75% = \$648.25	85% = \$779.60
		D 8:00 HOURS (44 basic uni	
23400	Fee: \$884.40	,	
23400		Benefit: 75% = \$663.30	
	8:01 HOURS TO 8:10 HOURS (45 basic units)		
23410	Fee: \$904.50	Benefit: 75% = \$678.40	85% = \$819.80

T10 DE	LATIVE VALUE G		
		ARE BENEFITS ARE	
	AYABLE FOR AN		
	RMED IN ASSOCI LE SERVICE	ATION WITH AN	21. ANAESTHESIA/PERFUSION TIME UNITS
22.0.01		8:20 HOURS (46 basic uni	
	8.11 HOUKS 10	8.20 HOURS (40 basic ull	(5)
23420	Fee: \$924.60	Benefit: 75% = \$693.45	85% = \$839.90
	8:21 HOURS TO	8:30 HOURS (47 basic uni	ts)
23430	Fee: \$944.70	Benefit: 75% = \$708.55	85% = \$860.00
	8:31 HOURS TO	8:40 HOURS (48 basic uni	ts)
23440	Fee: \$964.80	Benefit: 75% = \$723.60	85% = \$880.10
		8:50 HOURS (49 basic uni	
22.150		X	,
23450	Fee: \$984.90	Benefit: 75% = \$738.70	
	8:51 HOURS 10	9:00 HOURS (50 basic uni	IS)
23460	Fee: \$1,005.00	Benefit: 75% = \$753.75	85% = \$920.30
	9:01 HOURS TO	9:10 HOURS (51 basic uni	ts)
23470	Fee: \$1,025.10	Benefit: 75% = \$768.85	85% = \$940.40
	9:11 HOURS TO	9:20 HOURS (52 basic uni	ts)
23480	Fee: \$1,045.20	Benefit: 75% = \$783.90	85% - \$960 50
23400		9:30 HOURS (53 basic uni	
		X	,
23490	Fee: \$1,065.30	Benefit: 75% = \$799.00	
	9:31 HOURS TO	9:40 HOURS (54 basic uni	ts)
23500	Fee: \$1,085.40	Benefit: 75% = \$814.05	85% = \$1000.70
	9:41 HOURS TO	9:50 HOURS (55 basic uni	ts)
23510	Fee: \$1,105.50	Benefit: 75% = \$829.15	85% = \$1020.80
	9:51 HOURS TO	10:00 HOURS (56 basic ur	nits)
23520	Fee: \$1,125.60	Benefit: 75% = \$844.20	85% - \$1040.00
23320		O 10:10 HOURS (57 basic u	
		,	,
23530	Fee: \$1,145.70	Benefit: 75% = \$859.30	
	10:11 HOURS TO 10:20 HOURS (58 basic units)		
23540	Fee: \$1,165.80	Benefit: 75% = \$874.35	85% = \$1081.10
	10:21 HOURS T	O 10:30 HOURS (59 basic u	inits)
23550	Fee: \$1,185.90	Benefit: 75% = \$889.45	85% = \$1101.20
	· · ·	O 10:40 HOURS (60 basic u	
22560		,	, ,
23560	Fee: \$1,206.00	Benefit: 75% = \$904.50	85% = \$1121.30

	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA	
-	RMED IN ASSOCIATION WITH AN	
ELIGIBI	LE SERVICE 21. ANAESTHESIA/PERFUSION TIME UNITS	
	10:41 HOURS TO 10:50 HOURS (61 basic units)	
23570	Fee: \$1,226.10 Benefit: 75% = \$919.60 85% = \$1141.40	
	10:51 HOURS TO 11:00 HOURS (62 basic units)	
23580	Fee: \$1,246.20 Benefit: 75% = \$934.65 85% = \$1161.50	
	11:01 HOURS TO 11:10 HOURS (63 basic units)	
23590	Fee: \$1,266.30 Benefit: 75% = \$949.75 85% = \$1181.60	
	11:11 HOURS TO 11:20 HOURS (64 basic units)	
23600	Fee: \$1,286.40 Benefit: 75% = \$964.80 85% = \$1201.70	
23000	11:21 HOURS TO 11:30 HOURS (65 basic units)	
22(10		
23610	Fee: \$1,306.50 Benefit: 75% = \$979.90 85% = \$1221.80 11:31 HOURS TO 11:40 HOURS (66 basic units)	
23620	Fee: \$1,326.60 Benefit: 75% = \$994.95 85% = \$1241.90 11:41 HOURS TO 11:50 HOURS (67 basic units) \$1000000000000000000000000000000000000	
	11:41 HOURS TO 11:50 HOURS (67 basic units)	
23630	Fee: \$1,346.70 Benefit: 75% = \$1010.05 85% = \$1262.00	
	11:51 HOURS TO 12:00 HOURS (68 basic units)	
23640	Fee: \$1,366.80 Benefit: 75% = \$1025.10 85% = \$1282.10	
	12:01 HOURS TO 12:10 HOURS (69 basic units)	
23650	Fee: \$1,386.90 Benefit: 75% = \$1040.20 85% = \$1302.20	
	12:11 HOURS TO 12:20 HOURS (70 basic units)	
23660	Fee: \$1,407.00 Benefit: 75% = \$1055.25 85% = \$1322.30	
	12:21 HOURS TO 12:30 HOURS (71 basic units)	
23670	Fee: \$1,427.10 Benefit: 75% = \$1070.35 85% = \$1342.40	
	12:31 HOURS TO 12:40 HOURS (72 basic units)	
23680	Fee: \$1,447.20 Benefit: 75% = \$1085.40 85% = \$1362.50	
23000	EVEN: $51,447.20$ Benefit: $75\% = 1085.40 $85\% = 1362.50 12:41 HOURS TO 12:50 HOURS (73 basic units)	
22.000		
23690	Fee: \$1,467.30 Benefit: 75% = \$1100.50 85% = \$1382.60 12:51 HOURS TO 13:00 HOURS (74 basic units) 1000000000000000000000000000000000000	
	12:51 HOURS TO 13:00 HOURS (74 basic units)	
23700	Fee: \$1,487.40 Benefit: 75% = \$1115.55 85% = \$1402.70	
	13:01 HOURS TO 13:10 HOURS (75 basic units)	
23710	Fee: \$1,507.50 Benefit: 75% = \$1130.65 85% = \$1422.80	

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	
	13:11 HOURS TO 13:20 HOURS (76 basic units)	
23720	Fee: \$1,527.60 Benefit: 75% = \$1145.70 85% = \$1442.90	
23720	13:21 HOURS TO 13:30 HOURS (77 basic units)	
22720		
23730	Fee: \$1,547.70 Benefit: 75% = \$1160.80 85% = \$1463.00 13:31 HOURS TO 13:40 HOURS (78 basic units)	
23740	Fee: \$1,567.80 Benefit: 75% = \$1175.85 85% = \$1483.10	
	13:41 HOURS TO 13:50 HOURS (79 basic units)	
23750	Fee: \$1,587.90 Benefit: 75% = \$1190.95 85% = \$1503.20	
	13:51 HOURS TO 14:00 HOURS (80 basic units)	
23760	Fee: \$1,608.00 Benefit: 75% = \$1206.00 85% = \$1523.30	
	14:01 HOURS TO 14:10 HOURS (81 basic units)	
23770	Fee: \$1,628.10 Benefit: 75% = \$1221.10 85% = \$1543.40	
	14:11 HOURS TO 14:20 HOURS (82 basic units)	
23780	Fee: \$1,648.20 Benefit: 75% = \$1236.15 85% = \$1563.50	
	14:21 HOURS TO 14:30 HOURS (83 basic units)	
23790	Fee: \$1,668.30 Benefit: 75% = \$1251.25 85% = \$1583.60	
23170	14:31 HOURS TO 14:40 HOURS (84 basic units)	
22800		
23800	Fee: \$1,688.40 Benefit: 75% = \$1266.30 85% = \$1603.70 14:41 HOURS TO 14:50 HOURS (85 basic units)	
23810	Fee: \$1,708.50 Benefit: 75% = \$1281.40 85% = \$1623.80 14 51 HOURS TO 15 00 HOURS (861 min - 36) 35% = \$1623.80	
	14:51 HOURS TO 15:00 HOURS (86 basic units)	
23820	Fee: \$1,728.60 Benefit: 75% = \$1296.45 85% = \$1643.90	
	15:01 HOURS TO 15:10 HOURS (87 basic units)	
23830	Fee: \$1,748.70 Benefit: 75% = \$1311.55 85% = \$1664.00	
	15:11 HOURS TO 15:20 HOURS (88 basic units)	
23840	Fee: \$1,768.80 Benefit: 75% = \$1326.60 85% = \$1684.10	
	15:21 HOURS TO 15:30 HOURS (89 basic units)	
23850	Fee: \$1,788.90 Benefit: 75% = \$1341.70 85% = \$1704.20	
	15:31 HOURS TO 15:40 HOURS (90 basic units)	
23860	Fee: \$1,809.00 Benefit: 75% = \$1356.75 85% = \$1724.30	
23000	FOR ϕ 1 ,607,60 DETERM . 1 ,770 - ϕ 1 ,506,175 6 ,570 - ϕ 1 ,724,50	

T10. RELATIVE VALUE GUIDE FOR			
ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA			
PERFOR	MED IN ASSOCIATION WITH AN E SERVICE		
ELIGIBL		21. ANAESTHESIA/PERFUSION TIME UNITS	
	15:41 HOURS TO 15:50 HOURS (91 basic units)		
23870	Fee: \$1,829.10 Benefit: 75% = \$1371.85 85% =	= \$1744.40	
	15:51 HOURS TO 16:00 HOURS (92 basic units)		
23880	Fee: \$1,849.20 Benefit: 75% = \$1386.90 85% =	= \$1764.50	
	16:01 HOURS TO 16:10 HOURS (93 basic units)		
23890	Fee: \$1,869.30 Benefit: 75% = \$1402.00 85% =	= \$1784.60	
	16:11 HOURS TO 16:20 HOURS (94 basic units)		
23900	Fee: \$1.889.40 Benefit: 75% = \$1417.05 85% =	= \$1804.70	
	16:21 HOURS TO 16:30 HOURS (95 basic units)		
23910	Fee: \$1,909.50 Benefit: 75% = \$1432.15 85% =	- \$1824.80	
23910	16:31 HOURS TO 16:40 HOURS (96 basic units)	- \$1024.00	
23920	Fee: \$1,929.60 Benefit: 75% = \$1447.20 85% = 16:41 101 IPS TO 16:50 101 IPS 07 hegin units)	= \$1844.90	
	16:41 HOURS TO 16:50 HOURS (97 basic units)		
23930	Fee: \$1,949.70 Benefit: 75% = \$1462.30 85% =	= \$1865.00	
	16:51 HOURS TO 17:00 HOURS (98 basic units)		
23940	Fee: \$1,969.80 Benefit: 75% = \$1477.35 85% =	= \$1885.10	
	17:01 HOURS TO 17:10 HOURS (99 basic units)		
23950	Fee: \$1,989.90 Benefit: 75% = \$1492.45 85% =	= \$1905.20	
	17:11 HOURS TO 17:20 HOURS (100 basic units)		
23960	Fee: \$2,010.00 Benefit: 75% = \$1507.50 85% =	= \$1925.30	
	17:21 HOURS TO 17:30 HOURS (101 basic units)		
23970	Fee: \$2,030.10 Benefit: 75% = \$1522.60 85% =	- \$1945.40	
23710	17:31 HOURS TO 17:40 HOURS (102 basic units)		
22080	East \$2.050.20 Dama \$4.750/ \$1527.65 850/	¢1075.50	
23980	Fee: \$2,050.20 Benefit: 75% = \$1537.65 85% = 17:41 HOURS TO 17:50 HOURS (103 basic units)	= \$1903.30	
23990	Fee: \$2,070.30 Benefit: 75% = \$1552.75 85% =	= \$1985.60	
	17:51 HOURS TO 18:00 HOURS (104 basic units)		
24100	Fee: \$2,090.40 Benefit: 75% = \$1567.80 85% =	= \$2005.70	
	18:01 HOURS TO 18:10 HOURS (105 basic units)		
24101	Fee: \$2,110.50 Benefit: 75% = \$1582.90 85% =	= \$2025.80	

T10. RE	LATIVE VALUE GUIDE FOR
	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA
PERFO	RMED IN ASSOCIATION WITH AN
ELIGIBI	LE SERVICE 21. ANAESTHESIA/PERFUSION TIME UNITS
	18:11 HOURS TO 18:20 HOURS (106 basic units)
24102	Fee: \$2,130.60 Benefit: 75% = \$1597.95 85% = \$2045.90
	18:21 HOURS TO 18:30 HOURS (107 basic units)
24103	Fee: \$2,150.70 Benefit: 75% = \$1613.05 85% = \$2066.00
	18:31 HOURS TO 18:40 HOURS (108 basic units)
24104	Fee: \$2,170.80 Benefit: 75% = \$1628.10 85% = \$2086.10
	18:41 HOURS TO 18:50 HOURS (109 basic units)
24105	Fee: \$2,190.90 Benefit: 75% = \$1643.20 85% = \$2106.20
	18:51 HOURS TO 19:00 HOURS (110 basic units)
24106	Fee: \$2,211.00 Benefit: 75% = \$1658.25 85% = \$2126.30
24100	19:01 HOURS TO 19:10 HOURS (111 basic units)
24107	Fee: \$2,231.10 Benefit: 75% = \$1673.35 85% = \$2146.40
24107	Fee: $$2,231.10$ Benefit: $75\% = 1073.35 $85\% = 2146.40 19:11 HOURS TO 19:20 HOURS (112 basic units)
24108	Fee: \$2,251.20 Benefit: 75% = \$1688.40 85% = \$2166.50 10:21 HOURS TO 10:20 HOURS (112 basis series)
	19:21 HOURS TO 19:30 HOURS (113 basic units)
24109	Fee: \$2,271.30 Benefit: 75% = \$1703.50 85% = \$2186.60
	19:31 HOURS TO 19:40 HOURS (114 basic units)
24110	Fee: \$2,291.40 Benefit: 75% = \$1718.55 85% = \$2206.70
	19:41 HOURS TO 19:50 HOURS (115 basic units)
24111	Fee: \$2,311.50 Benefit: 75% = \$1733.65 85% = \$2226.80
	19:51 HOURS TO 20:00 HOURS (116 basic units)
24112	Fee: \$2,331.60 Benefit: 75% = \$1748.70 85% = \$2246.90
	20:01 HOURS TO 20:10 HOURS (117 basic units)
24113	Fee: \$2,351.70 Benefit: 75% = \$1763.80 85% = \$2267.00
	20:11 HOURS TO 20:20 HOURS (118 basic units)
24114	Fee: \$2,371.80 Benefit: 75% = \$1778.85 85% = \$2287.10
	20:21 HOURS TO 20:30 HOURS (119 basic units)
24115	Fee: \$2,391.90 Benefit: 75% = \$1793.95 85% = \$2307.20
24113	Deficit: $75\% = 1793.95 $85\% = 2307.20 20:31 HOURS TO 20:40 HOURS (120 basic units)
24116	Fee: \$2,412.00 Benefit: 75% = \$1809.00 85% = \$2327.30

T10. RE	LATIVE VALUE GUIDE FOR	
	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA	
PERFO	RMED IN ASSOCIATION WITH AN	
ELIGIBI		21. ANAESTHESIA/PERFUSION TIME UNITS
	20:41 HOURS TO 20:50 HOURS (121 basic unit	s)
24117	Fee: \$2,432.10 Benefit: 75% = \$1824.10 85	5% = \$2347.40
	20:51 HOURS TO 21:00 HOURS (122 basic unit	s)
24118	Fee: \$2,452.20 Benefit: 75% = \$1839.15 85	5% = \$2367.50
	21:01 HOURS TO 21:10 HOURS (123 basic unit	s)
24119	Fee: \$2,472.30 Benefit: 75% = \$1854.25 85	5% = \$2387.60
	21:11 HOURS TO 21:20 HOURS (124 basic unit	s)
24120	Fee: \$2,492.40 Benefit: 75% = \$1869.30 85	5% = \$2407.70
	21:21 HOURS TO 21:30 HOURS (125 basic unit	
24121	Fee: \$2,512.50 Benefit: 75% = \$1884.40 85	5% — \$2427.80
24121	21:31 HOURS TO 21:40 HOURS (126 basic unit	
24122	Fee: \$2,532.60 Benefit: 75% = \$1899.45 85	
24122	21:41 HOURS TO 21:50 HOURS (127 basic unit	
		, ,
24123	Fee: \$2,552.70 Benefit: 75% = \$1914.55 85 21:51 HOURS TO 22:00 HOURS (128 basic unit	
24124	Fee: \$2,572.80 Benefit: 75% = \$1929.60 85	
	22:01 HOURS TO 22:10 HOURS (129 basic unit	s)
24125	Fee: \$2,592.90 Benefit: 75% = \$1944.70 85	
	22:11 HOURS TO 22:20 HOURS (130 basic unit	s)
24126	Fee: \$2,613.00 Benefit: 75% = \$1959.75 85	5% = \$2528.30
	22:21 HOURS TO 22:30 HOURS (131 basic unit	s)
24127	Fee: \$2,633.10 Benefit: 75% = \$1974.85 85	5% = \$2548.40
	22:31 HOURS TO 22:40 HOURS (132 basic unit	s)
24128	Fee: \$2,653.20 Benefit: 75% = \$1989.90 85	5% = \$2568.50
	22:41 HOURS TO 22:50 HOURS (133 basic units)	
24129	Fee: \$2,673.30 Benefit: 75% = \$2005.00 85	5% = \$2588.60
	22:51 HOURS TO 23:00 HOURS (134 basic unit	
24130	Fee: \$2,693.40 Benefit: 75% = \$2020.05 85	5% — \$2608 70
27130	23:01 HOURS TO 23:10 HOURS (135 basic unit	
24121		
24131	Fee: \$2,713.50 Benefit: 75% = \$2035.15 85	9% = \$2628.80

ANAES ONLY P PERFOR	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 21. ANAESTHESIA/PERFUSION TIME UNITS
	23:11 HOURS TO 23:20 HOURS (136 basic units)
24132	Fee: \$2,733.60 Benefit: 75% = \$2050.20 85% = \$2648.90
	23:21 HOURS TO 23:30 HOURS (137 basic units)
24133	Fee: \$2,753.70 Benefit: 75% = \$2065.30 85% = \$2669.00
	23:31 HOURS TO 23:40 HOURS (138 basic units)
24134	Fee: \$2,773.80 Benefit: 75% = \$2080.35 85% = \$2689.10
	23:41 HOURS TO 23:50 HOURS (139 basic units)
24135	Fee: \$2,793.90 Benefit: 75% = \$2095.45 85% = \$2709.20
	23:51 HOURS TO 24:00 HOURS (140 basic units)
24136	Fee: \$2,814.00 Benefit: 75% = \$2110.50 85% = \$2729.30
	RMED IN ASSOCIATION WITH AN 22. ANAESTHESIA/PERFUSION MODIFYING LE SERVICE UNITS - PHYSICAL STATUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
	Anaesthesia Performed In Association With An Eligible Service
	Subgroup 22. Anaesthesia/Perfusion Modifying Units - Physical Status
	Subgroup 22. Anaesthesia/Perfusion Modifying Units - Physical Status
	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
	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
	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
25000	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
25000	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) (See para TN.10.3 of explanatory notes to this Category)
25000	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) (See para TN.10.3 of explanatory notes to this Category) Fee: \$20.10 Benefit: 75% = \$15.10 85% = \$17.10 Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA
	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) (See para TN.10.3 of explanatory notes to this Category) Fee: \$20.10 Benefit: 75% = \$15.10 85% = \$17.10 Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units) (See para TN.10.3 of explanatory notes to this Category)

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

22. ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS

Fee: \$60.30

30 **Benefit:** 75% = \$45.25 85% = \$51.30

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

23. ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service	
	Subgroup 23. Anaesthesia/Perfusion Modifying Units - Other	
	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is over 3 years of age but under 4 years of age (1 basic units)	
25012	Fee: \$20.10 Benefit: 75% = \$15.10 85% = \$17.10	
	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged not more than 3 years or at least 75 years (1 basic units)	
25015	Fee: \$20.10 Benefit: 75% = \$15.10 85% = \$17.10	
	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA	
	- where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 basic units)	
25020	(See para TN.10.3 of explanatory notes to this Category) Fee: $$40.20$ Benefit: $75\% = 30.15 $85\% = 34.20	
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR STHESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA ORMED IN ASSOCIATION WITH AN 24. ANAESTHESIA AFTER HOURS EMERGENCY LE SERVICE MODIFIER	
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR STHESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA PRMED IN ASSOCIATION WITH AN 24. ANAESTHESIA AFTER HOURS EMERGENCY	
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR STHESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 24. ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For	
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR STHESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA PRMED IN ASSOCIATION WITH AN LE SERVICE 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	

24. ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER

ELIGIB	LE SERVICE	MODIFIER	
	the range 22001-22051		
	immediate treatment without which there we than 50% of the time for which the assistant the after hours period, being the period from	GENCY ANAESTHESIA where the patient requires ould be significant threat to life or body part and where more is in professional attendance on the patient is provided in 8pm to 8am on any weekday, or at any time on a Saturday, ervice associated with a service to which item 25020, 25025	
25030	(See para TN.10.3 of explanatory notes to this Ca Derived Fee: An additional amount of 50% of t (a) an assistant anaesthesia item in the range 2520 (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000- (d) where performed, any associated therapeutic of	the fee for assistance at anaesthesia. That is: 00 - 25205, plus 25015, plus	
	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA		
	RMED IN ASSOCIATION WITH AN LE SERVICE	25. PERFUSION AFTER HOURS EMERGENCY MODIFIER	
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	Subgroup 25. Perfusion After Hours Emergency Modifier		
	AFTER HOURS EMERGENCY PERFUSION where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25030 applies (0 basic units)		
	(See para TN.10.3 of explanatory notes to this Category) Derived Fee: An additional amount of 50% of the fee for the perfusion service. That is:		
	 (a) item 22060, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015, plus 		
25050		or diagnostic service/s in the range 22001-22051 or 22065-22075	
ANAES ONLY F	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN		
-	LE SERVICE	26. ASSISTANCE AT ANAESTHESIA	
	Group T10. Relative Value Guide For Ana Anaesthesia Performed In Association Wi	esthesia - Medicare Benefits Are Only Payable For ith An Eligible Service	
	Subgroup 2	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

26. ASSISTANCE AT ANAESTHESIA

	units)
	(See para TN.10.9 of explanatory notes to this Category)
	Derived Fee: An amount of \$100.50 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051
	ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA where:
	(i) the patient has complex airway problems; or
	(ii) the patient is a neonate or a complex paediatric case; or
	(iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or
	(iv) the patient is critically ill, with multiple organ failure; or
	(v) where the anaesthesia time exceeds 6 hours
	and the assistance is provided to the exclusion of all other patients (5 basic units)
25205	(See para TN.10.9 of explanatory notes to this Category) Derived Fee: An amount of \$100.50 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051
T11. BC	DTULINUM TOXIN INJECTIONS
	Group T11. Botulinum Toxin Injections
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of
18350	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of
18350	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 (See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85 Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the
	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 (See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85 Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on
18350 18351	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 (See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85 Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day (See para TN.11.1 of explanatory notes to this Category)
18350 18351 18353	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 (See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85 Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day (See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85 Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day (See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85 Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the

T11. BC	DTULINUM TOXIN INJECTIONS
	patient, if:
	(a) the patient is at least 2 years of age; and
	(b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each lower limb), including all injections per set (Anaes.)
	(See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), or Clostridium Botulinum Type A Toxin Haemagglutinin Complex (Dysport), injection of, for the treatment of moderate to severe focal spasticity, if:
	(a) the patient is at least 18 years of age; and
	(b) the spasticity is associated with a previously diagnosed neurological disorder; and
	(c) treatment is provided as:
	(i) second line therapy when standard treatment for the conditions has failed; or
	(ii) an adjunct to physical therapy; and
	(d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each limb), including all injections per set; and
	(e) the treatment is not provided on the same occasion as a service mentioned in item 18365
18360	(See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if:
	(a) the patient is at least 2 years of age, and
	(b) for a patient who is at least 18 years of age - before the patient turned 18, the patient had commenced treatment for the spasticity with botulinum toxin supplied under the pharmaceutical benefits scheme; and
	(c) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.)
18361	(See para TN.11.1 of explanatory notes to this Category)Fee: $$126.85$ Benefit: $75\% = 95.15 $85\% = 107.85
	Botulinum Toxin type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of severe primary axillary hyperhidrosis, including all injections on any one day, if:
	(a) the patient is at least 12 years of age; and
18362	(b) the patient has been intolerant of, or has not responded to, topical aluminium chloride hexahydrate; and

T11. BC	DTULINUM TOXIN INJECTIONS
	(c) the patient has not had treatment with botulinum toxin within the immediately preceding 4 months; and
	(d) if the patient has had treatment with botulinum toxin within the previous 12 months - the patient had treatment on no more than 2 separate occasions (Anaes.)
	(See para TN.11.1 of explanatory notes to this Category) Fee: \$250.65 Benefit: 75% = \$188.00 85% = \$213.10
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of moderate to severe spasticity of the upper limb following a stroke, if:
	(a) the patient is at least 18 years of age; and
	(b) treatment is provided as:
	(i) second line therapy when standard treatment for the condition has failed; or
	(ii) an adjunct to physical therapy; and
	(c) the patient does not have established severe contracture in the limb that is to be treated; and
	(d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and
	(e) for a patient who has received treatment on 2 previous separate occasions - the patient has responded to the treatment
18365	(See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of strabismus, including all such injections on any one day and associated electromyography (Anaes.)
18366	(See para TN.11.1 of explanatory notes to this Category) Fee: \$158.90 Benefit: 75% = \$119.20 85% = \$135.10
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day
18368	(See para TN.11.1 of explanatory notes to this Category) Fee: \$271.30 Benefit: 75% = \$203.50 85% = \$230.65
	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)
18369	(See para TN.11.1 of explanatory notes to this Category) Fee: \$45.75 Benefit: 75% = \$34.35 85% = \$38.90
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.)
18370	(See para TN.11.1 of explanatory notes to this Category) Fee: \$45.75 Benefit: 75% = \$34.35 85% = \$38.90
18372	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of

T11. BO	TULINUM TOXIN INJECTIONS
	bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day (Anaes.)
	(See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85
	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)
18374	(See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if:
	(a) the urinary incontinence is due to neurogenic detrusor overactivity as demonstrated by urodynamic study of a patient with:
	(i) multiple sclerosis; or
	(ii) spinal cord injury; or
	(iii) spina bifida and who is at least 18 years of age; and
	(b) the patient has urinary incontinence that is inadequately controlled by anti-cholinergic therapy, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin type A; and
	(c) the patient is willing and able to self-catheterise; and
	(d) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with; and
	(e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919
18375	For each patient - applicable not more than once except if the patient achieves at least a 50% reduction in

T11. BO	TULINUM TOXIN INJECTIONS
	urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.)
	(See para TN.11.1 of explanatory notes to this Category) Fee: \$233.55 Benefit: 75% = \$175.20
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in 1 day, if:
	(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)
18377	(See para TN.11.1 of explanatory notes to this Category) Fee: \$126.85 Benefit: 75% = \$95.15 85% = \$107.85
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if:
	(a) the urinary incontinence is due to idiopathic overactive bladder in a patient: and
	(b) the patient is at least 18 years of age; and
	(c) the patient has urinary incontinence that is inadequately controlled by at least 2 alternative anti-
	cholinergic agents, as manifested by having experienced at least 14 episodes of urinary incontinence per week
	before commencement of treatment with botulinum toxin; and
	(d) the patient is willing and able to self-catheterise; and
	(e) treatment is not provided on the same occasion as a service mentioned in item 104, 105, 110, 116, 119, 11900 or 11919
	For each patient-applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment
	(H) (Anaes.)
18379	(See para TN.11.1 of explanatory notes to this Category) Fee: \$233.55 Benefit: 75% = \$175.20

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