Australian Government

Department of Health and Aged Care

Medicare Benefits Schedule Book

Category 3

Operating from 1 July 2023

Title: Medicare Benefits Schedule Book

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

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

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GN.0.1 AskMBS Email Advice Service

If you are a patient seeking advice about Medicare services, benefits or your Medicare claims, please contact Services Australia on the Medicare general enquiry line - 132 011.

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

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

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

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

GN.1.1 The Medicare Benefits Schedule - Introduction

Schedules of Services

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

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

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

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

Explanatory Notes

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

GN.1.2 Medicare - an outline

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

a. Free treatment for public patients in public hospitals.
b. The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). The relevant benefit rates are:

i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients, or for general practitioner attendances specified as not being hospital treatments - see note below;
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 services provided to public patients), including services provided in hospital outpatient settings but not generally including services set out in the note below. 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', 'hospital outpatient service', 'admitted' or 'in patient');
iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment such as ‘hospital in the home’, but generally not including certain services listed below. 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';
v. 85% of the Schedule fee for all other services.

Note: while hospital treatments and hospital-substitute treatments attract a 75% rebate, most attendances, services provided to private patients in emergency departments, pathology services and diagnostic imaging services do not generally require hospital treatment and therefore do not attract a rebate of 75% of the Schedule fee unless certified as a 'Type C' treatment. A list of most MBS items in scope of this exception, and the requirements around certifying a treatment as 'Type C' can be found in the *Private Health Insurance (Benefit Requirement) Rules 2011*. Services provided to a private patient in an emergency department are exempted under the *Private Health Insurance (Health Insurance Business) Rules 2018*.

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, Services Australia may request its return from the practitioner concerned.

* MBS items 10988 and 10989 generally attract a 100% rebate but can be specified as 'Type C' treatments and attract a 75% rebate.

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

Services Australia (SA) has developed a Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service. There is also a Health Practitioner Guideline for substantiating that a specific treatment was performed. These guidelines are located on the SA 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 Services Australia 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 Services Australia for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from the Services Australia 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 and Aged Care.

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.

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 Services Australia (provider liaison - 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

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

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

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

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

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

GN.2.7 Overseas trained doctor

Ten year moratorium

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

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

Exclusions - Practitioners who before 1 January 1997 had

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

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

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

GN.2.8 Contact details for Services Australia

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

Changes to Provider Contact Details

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

Medicare

GPO Box 9822

in your capital city

or

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

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

GN.3.9 Patient eligibility for Medicare

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

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

GN.3.10 Medicare cards

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

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

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

GN.3.11 Visitors to Australia and temporary residents

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

GN.3.12 Reciprocal Health Care Agreements

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

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

Exceptions:

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

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

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

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 Services Australia, having completed an application form available from Services Australia's website. A general practice trainee should apply to General Practice Education and Training Limited (GPET) for a general practitioner trainee placement. GPET will advise

Services Australia when a placement is approved. General practitioner trainees need to apply for a provider number using the appropriate provider number application form available on Services Australia's website.

Vocational recognition of general practitioners

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

(a) certification by the RACGP that the practitioner

· is a Fellow of the RACGP; and

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

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

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

· is a Fellow of the RACGP; and

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

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

(c) certification by ACRRM that the practitioner

· is a Fellow of ACRRM; and

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

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

Further information on eligibility for recognition should be directed to:

QI&CPD Program Administrator, RACGP

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

Secretary, General Practice Recognition Eligibility Committee:

Email at gprec@health.gov.au

Executive Assistant, ACRRM:

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

How to apply for vocational recognition

Medical practitioners seeking vocational recognition should apply to Services Australia using the approved Application Form available on the Services Australia website: https://www.servicesaustralia.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 and Aged

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 and Aged Care

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 Services Australia CEO for processing.

Continued vocational recognition is dependent upon:

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

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

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

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

Removal of vocational recognition status

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

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

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

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

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

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

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

A relevant specialist College may also give Services Australia' 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 Services Australia's Medicare website.

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

Further information about applying for recognition is available at the Services Australia's Medicare website.

Services Australia (SA) has developed an Health Practitioner Guideline to substantiate that a valid referral existed (specialist or consultant physician) which is located on the SA website.

GN.5.15 Emergency Medicine

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

(a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or

(b) suffering from suspected acute organ or system failure; or

(c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or

(d) suffering from a drug overdose, toxic substance or toxin effect; or

(e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or

(f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or

(g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and

(h) treated in, or via, a bona fide emergency department in a hospital.

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

GN.5.16 Conjoint Committee for recognising training in Micro Bypass Glaucoma Surgery (MBGS)

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

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

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

A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services. Information about the form of a diagnostic imaging request can be found in **Note IN.0.6** of the Diagnostic Imaging Services Table (Category 5) and information about the form of a pathology request can be found in **Note PN.2.1** of the Pathology Services Table (Category 6).

What is a Referral?

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

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

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

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

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

The exceptions to the requirements in paragraph above are that

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

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

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

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

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

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

Examination by Specialist Anaesthetists

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

Who can Refer?

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

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

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:

(a) by a registered dental practitioner, where the referral arises from a dental service; or

(b) by a registered optometrist where the specialist is an ophthalmologist; or

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

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

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

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

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

Billing

Routine Referrals

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

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

- date of referral; and

- period of referral (when other than for 12 months) expressed in months, e.g. "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 (e.g. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

Definition of a Single Course of Treatment

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

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

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

However, where the referring practitioner:-

(a) deems it necessary for the patient's condition to be reviewed; and

(b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and

(c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier

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

Retention of Referral Letters

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

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

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

Attendance for Issuing of a Referral

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

Locum-tenens Arrangements

It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the level appropriate for the particular locum-tenens, e.g., 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 i.e. 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 Services Australia website contains information on Medicare billing and claiming options. Please visit the Services Australia 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.

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

Following a review, the Director must:

decide to take no further action; or

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

refer the matter to a PSR Committee.

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

The Committee is authorized to:

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

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

require the production of documents (including clinical notes).

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

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

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

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

an unusual occurrence;

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

the characteristics of the patients.

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

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

Additional Information

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their

decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records (See general explanatory note G15.1 for more information on adequate and contemporaneous patient records).

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

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

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

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

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 - www.msac.gov.au or email on msac.secretariat@health.gov.au 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 services provided to 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', 'hospital outpatient service', 'admitted' or 'in patient'). Certain services are not generally considered hospital treatments – see GN1.2;
    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'. Certain services are not generally considered hospital treatments – see GN1.2.

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 – see GN1.2 for exceptions.
c. 85% of the Schedule fee, or the Schedule fee less $93.20 (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 2020-2025 Addendum to the National Health Reform Agreement.

Where a Medicare item with multiple components is provided, and some components are provided in the hospital and the remainder outside of the hospital (e.g. aftercare), the 75% benefit level applies. 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 if not a type of item specified in GN1.2 as not generally being a hospital treatment.

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. Patients 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 individuals 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 (OMSN) and the Extended Medicare Safety Net (EMSN).

Original Medicare Safety Net:

Under the OMSN, 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 2023 is $531.70. This threshold applies to all Medicare-eligible individuals and families.

Extended Medicare Safety Net:

Under the EMSN, once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for up to 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 2023, the threshold for concessional individuals and families, including families that received Family Tax Benefit Part (A), is $770.30. The threshold for all other (non-concessional) individuals and families in 2023 is $2,414.00.

The thresholds for both safety nets are indexed on 1 January each year in line with the Consumer Price Index (CPI).

Individuals are automatically registered with Services Australia for the safety nets. Families (including couples) are required to register in order to be recognised as a family for the purposes of 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 completed online at https://www.servicesaustralia.gov.au/individuals/services/medicare/medicare-safety-nets.

EMSN Benefit Caps:

The EMSN benefit cap is the maximum EMSN benefit payable for that item and is paid in addition to the standard Medicare rebate. Where there is an EMSN benefit cap in place for the item, the amount of the EMSN cap is displayed in the item descriptor. Once the EMSN threshold is reached, each time the item is claimed the patient is eligible to receive up to the EMSN benefit cap. In other words, once the patient reaches the EMSN threshold, they will receive either 80% of their out-of-pocket costs back or the EMSN cap amount, whichever is the lower amount.

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

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

o If the fee charged by the doctor for Item A is $110, the standard Medicare rebate is $85, with an out-of-pocket cost of $25. The EMSN benefit is calculated as $25 x 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).

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

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

GN.11.29 Ministerial Determinations

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

GN.12.30 Professional services

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

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

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

(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11304, 11600, 11627, 11705, 11724, 11728, 11729, 11730, 11731, 11921, 12000, 12003;

(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13750-13760, 13950, 14050, 14221 and 14245);

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

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

(f) All Group T4 (Obstetrics) items (except 16400 and 16514);

(g) All Group T6 (Anaesthetics) items;

(h) All Group T7 (Regional or Field Nerve Block) items;

(i) All Group T8 (Operations) items;

(j) All Group T9 (Assistance at Operations) items;

(k) All Group T10 (Relative Value Guide for Anaesthetics) items.

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

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

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

GN.12.31 Services rendered on behalf of medical practitioners

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

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

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

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

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

Supervision from outside of Australia is not acceptable.

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

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

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

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

GN.12.32 Medicare benefits and vaccinations

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

Example 1

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

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

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

Example 2

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

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

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

Example 3

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

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

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

GN.13.33 Services which do not attract Medicare benefits

Services not attracting benefits

(a) telephone consultations (with the exception of COVID-19 telehealth services);

(b) issue of repeat prescriptions when the patient does not attend the surgery in person;

(c) group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);

(d) non-therapeutic cosmetic surgery;

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

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

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

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

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

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

Unless the Minister otherwise directs

Medicare benefits are not payable where:

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

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

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

(d) the service is a health screening service.

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

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

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

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

(c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;

(d) the removal of tattoos;

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

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

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

Pain pumps for post-operative pain management

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

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

Non Medicare Services

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

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

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

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

(b) gamma knife surgery;

(c) intradiscal electro thermal arthroplasty;

(d) intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);

(e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;

(f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;

(g) lung volume reduction surgery, for advanced emphysema;

(h) photodynamic therapy, for skin and mucosal cancer;

(i) placement of artificial bowel sphincters, in the management of faecal incontinence;

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

(k) specific mass measurement of bone alkaline phosphatase;

(l) transmyocardial laser revascularisation;

(m) vertebral axial decompression therapy, for chronic back pain;

(n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation;

(o) 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.

Services Australia (SA) has developed an Health Practitioner Guideline to substantiate that a specific treatment was performed which is located on the SA website.

CATEGORY 3: THERAPEUTIC PROCEDURES

SUMMARY OF CHANGES FROM 01/07/2023

The 01/07/2023 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

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

Deleted Items

30017	30020	30165	30168	30171	30172	30300	30302	30303	30335	31524	39333	45024
45039	45042	45215	45218	45236	45240	45400	45403	45406	45409	45412	45415	45418
45439	45442	45445	45448	45460	45461	45462	45464	45465	45466	45468	45469	45471
45472	45474	45475	45477	45478	45480	45481	45483	45484	45485	45486	45487	45488
45489	45490	45491	45492	45493	45494	45498	45499	45506	45519	45533	45536	45569
45570	45593	45647	45662	45720	45723	45726	45729	45731	45732	45735	45738	45741
45744	45747	45752	45753	45754	45755	45758	45770	45799	45803	45805	45817	45819
45821	45833	45835	45839	45843	45853	45859	45861	45863	45867	45869	45875	45877
45879	45885	45897	45900	45945	45975	45978	45981	45984	45987	45990	45993	45996
47756	47768	47771	47774	47777	47780	47783						

New Items

30007	30015	30016	30166	30169	30305	31227	31344	31386	31387	31388	31513	31514
31520	31522	31523	31526	31528	31529	45440	45443	45507	45510	45529	45531	45532
45537	45538	45540	45541	45547	45567	45571	45592	45594	45609	45717	45718	45874
46050	46052	46060	46062	46064	46066	46068	46070	46072	46080	46082	46084	46086
46088	46090	46092	46094	46100	46101	46102	46103	46104	46105	46106	46107	46108
46109	46110	46111	46112	46113	46114	46115	46116	46117	46118	46119	46120	46121
46122	46123	46124	46125	46126	46127	46128	46129	46130	46131	46132	46133	46134
46135	46136	46140	46141	46142	46143	46150	46151	46152	46153	46154	46155	46156
46157	46158	46159	46160	46161	46170	46171	46172	46173	46174	46175	46176	46177
46178	46179	46180	46181	46182	46183	46184	46185	47766				

Description Amended

13761	13762	16003	16006	16009	16012	16015	16018	30003	30006	30010	30014	30175
30176	30177	30179	30299	30311	30332	30336	30630	30651	30655	31220	31225	31340
31345	31356	31358	31359	31361	31363	31365	31367	31369	31512	31519	31525	31563
32221	38680	39329	45000	45003	45006	45012	45021	45027	45030	45033	45035	45036
45045	45054	45200	45201	45203	45206	45207	45209	45212	45239	45451	45497	45500
45501	45502	45503	45504	45505	45515	45518	45520	45522	45523	45524	45527	45528
45530	45534	45535	45539	45542	45556	45558	45561	45562	45563	45564	45565	45566
45568	45572	45581	45585	45590	45596	45597	45599	45608	45611	45614	45644	45660
45661	45665	45671	45674	45677	45680	45683	45686	45714	45761	45767	45773	45782
45785	45788	45791	45794	45797	45801	45815	45823	45831	45845	45847	45849	45851
45855	45857	45873	45894	47000	47753	47762	47765	47786	47789	49706	51300	51303

Fee Amended

13015	13020	13025	13030	13100	13103	13104	13105	13106	13109	13110	13200	13201
13202	13203	13207	13209	13212	13215	13218	13221	13241	13251	13260	13290	13300
13303	13306	13309	13312	13318	13319	13400	13506	13700	13703	13706	13750	13755
13757	13760	13761	13762	13815	13818	13830	13832	13834	13835	13837	13838	13839
13840	13842	13848	13851	13854	13857	13870	13873	13876	13881	13882	13885	13888
13899	13950	14050	14100	14106	14115	14118	14124	14201	14202	14203	14206	14212

14216	14217	14218	14219	14220	14221	14224	14227	14234	14237	14245	14247	14249
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14278	14280	14283	14285	14288	15000	15003	15006	15009	15012	15100	15103	15106
15109	15112	15115	15211	15214	15215	15218	15221	15224	15227	15230	15233	15236
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15303	15304	15307	15308	15311	15312	15315	15316	15319	15320	15323	15324	15327
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15536	15539	15550	15553	15555	15556	15559	15562	15565	15600	15700	15705	15710
15715	15800	15850	15900	16003	16006	16009	16012	16015	16018	16400	16401	16404
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36672 36673 36800 36803 36806 36809 36811 36812 36815 36818 36821 36822 36823
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37216 37217 37218 37219 37220 37221 37223 37224 37226 37227 37230 37233 37245

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38670	38673	38677	38680	38700	38703	38706	38709	38715	38718	38721	38724	38727
38730	38733	38736	38739	38742	38745	38748	38751	38754	38757	38760	38764	38766
38800	38803	38812	38815	38816	38817	38818	38820	38821	38822	38823	38824	38828
38829	38830	38831	38832	38833	38834	38837	38838	38839	38840	38841	38842	38845
38846	38847	38848	38849	38850	38851	38852	38853	38857	38858	38859	38864	39000
39007	39013	39014	39015	39018	39100	39109	39110	39111	39113	39116	39117	39118
39119	39121	39124	39125	39126	39127	39128	39129	39130	39131	39133	39134	39135
39136	39137	39138	39139	39140	39141	39300	39303	39306	39307	39309	39312	39315
39318	39319	39321	39323	39324	39327	39328	39329	39330	39331	39332	39333	39336
39339	39342	39345	39503	39604	39610	39612	39615	39638	39639	39641	39651	39654
39656	39700	39703	39710	39712	39715	39718	39720	39801	39803	39815	39818	39821
39900	39903	39906	40004	40012	40018	40104	40106	40109	40112	40119	40600	40700
40701	40702	40703	40704	40705	40706	40707	40708	40709	40712	40801	40803	40850
40851	40852	40854	40856	40858	40860	40862	40863	40905	41500	41501	41503	41506
41509	41512	41515	41518	41521	41524	41527	41530	41533	41536	41539	41542	41545
41548	41551	41554	41557	41560	41563	41564	41566	41569	41572	41575	41576	41578
41579	41581	41584	41587	41590	41593	41596	41599	41603	41608	41611	41614	41615
41617	41618	41620	41623	41626	41629	41632	41635	41638	41641	41644	41647	41650
41656	41659	41662	41668	41671	41674	41677	41683	41686	41689	41692	41693	41698
41701	41702	41703	41704	41705	41707	41710	41713	41719	41722	41725	41728	41734
41737	41740	41743	41746	41749	41752	41755	41764	41770	41776	41779	41785	41786
41789	41793	41797	41801	41804	41807	41810	41813	41822	41825	41828	41831	41832
41834	41837	41840	41843	41855	41861	41867	41870	41873	41876	41879	41880	41881
41884	41885	41886	41887	41888	41890	41907	41910	42503	42504	42505	42506	42509
42510	42512	42515	42518	42521	42524	42527	42530	42533	42536	42539	42542	42543
42545	42548	42551	42554	42557	42563	42569	42572	42573	42574	42575	42576	42581
42584	42587	42588	42590	42593	42596	42599	42602	42605	42608	42610	42611	42614
42615	42617	42620	42622	42623	42626	42629	42632	42635	42638	42641	42644	42647
42650	42651	42652	42653	42656	42662	42665	42667	42668	42672	42673	42676	42677
42680	42683	42686	42689	42692	42695	42698	42701	42702	42703	42704	42705	42707
42710	42713	42716	42719	42725	42731	42734	42738	42739	42740	42741	42743	42744
42746	42749	42752	42755	42758	42761	42764	42767	42770	42773	42776	42779	42782
42785	42788	42791	42794	42801	42802	42805	42806	42807	42808	42809	42810	42811
42812	42815	42818	42821	42824	42833	42836	42839	42842	42845	42848	42851	42854
42857	42860	42863	42866	42869	42872	43021	43022	43023	43521	43527	43530	43533
43801	43804	43805	43807	43810	43813	43816	43819	43822	43825	43828	43831	43832
43834	43835	43837	43838	43840	43841	43843	43846	43849	43852	43855	43858	43861
43864	43867	43870	43873	43876	43879	43882	43900	43903	43906	43909	43912	43915
43930	43933	43936	43939	43942	43945	43948	43951	43954	43957	43960	43963	43966
43969	43972	43975	43978	43981	43984	43987	43990	43993	43996	43999	44101	44102
44104	44105	44108	44111	44114	44130	44133	44136	44325	44328	44331	44334	44338
44342	44346	44350	44354	44358	44359	44361	44364	44367	44370	44373	45000	45003
45006	45009	45012	45015	45018	45019	45021	45024	45025	45026	45027	45030	45033
45035	45036	45039	45042	45045	45048	45051	45054	45060	45061	45062	45200	45201
45202	45203	45206	45207	45209	45212	45221	45224	45227	45230	45233	45239	45451
45496	45497	45500	45501	45502	45503	45504	45505	45512	45515	45518	45520	45522
45523	45524	45527	45528	45530	45534	45535	45539	45542	45545	45546	45548	45551

45553 45554 45556 45558 45560 45561 45562 45563 45564 45565 45566 45568 45572
45575 45578 45581 45584 45585 45587 45588 45589 45590 45596 45597 45599 45602
45605 45608 45611 45614 45617 45620 45623 45624 45625 45626 45627 45629 45632
45635 45641 45644 45645 45646 45650 45652 45653 45656 45658 45659 45660 45661
45665 45668 45669 45671 45674 45675 45676 45677 45680 45683 45686 45689 45692
45695 45698 45701 45704 45707 45710 45713 45714 45716 45761 45767 45773 45776
45779 45782 45785 45788 45791 45794 45797 45801 45807 45809 45811 45813 45815
45823 45825 45827 45829 45831 45837 45841 45845 45847 45849 45851 45855 45857
45865 45871 45873 45882 45888 45891 45894 45897 45939 46300 46303 46308 46309
46312 46315 46318 46321 46322 46324 46325 46330 46333 46335 46336 46339 46340
46341 46342 46345 46348 46351 46354 46357 46360 46363 46364 46365 46367 46370
46372 46375 46378 46379 46380 46381 46384 46387 46390 46393 46394 46395 46399
46401 46408 46411 46414 46417 46420 46423 46426 46432 46434 46438 46441 46442
46444 46450 46453 46456 46464 46465 46468 46471 46474 46477 46480 46483 46486
46489 46492 46493 46495 46498 46500 46501 46502 46503 46504 46507 46510 46513
46519 46522 46525 46528 46531 46534 47000 47003 47007 47009 47012 47015 47018
47021 47024 47027 47030 47033 47042 47045 47047 47049 47052 47053 47054 47057
47060 47063 47066 47069 47301 47304 47307 47310 47313 47316 47319 47348 47351
47354 47357 47361 47362 47364 47367 47370 47373 47381 47384 47385 47386 47387
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47549 47552 47555 47558 47559 47561 47565 47566 47568 47570 47573 47579 47582
47585 47588 47591 47592 47593 47595 47597 47600 47603 47612 47615 47618 47621
47624 47630 47637 47639 47648 47657 47663 47666 47672 47678 47735 47738 47741
47753 47762 47765 47786 47789 47790 47791 47792 47900 47903 47904 47906 47915
47916 47918 47921 47924 47927 47929 47953 47954 47955 47956 47960 47964 47967
47975 47978 47981 47982 47983 47984 48245 48248 48251 48254 48257 48400 48403
48406 48409 48412 48415 48419 48420 48421 48422 48423 48424 48426 48427 48430
48433 48435 48507 48509 48512 48900 48903 48906 48909 48915 48918 48921 48924
48927 48939 48942 48945 48948 48951 48954 48958 48960 48972 48980 48983 48986
49100 49104 49105 49106 49109 49112 49115 49116 49117 49118 49121 49124 49200
49203 49206 49209 49210 49212 49213 49215 49218 49219 49220 49221 49224 49227
49230 49233 49236 49239 49300 49303 49306 49309 49315 49318 49319 49321 49360
49363 49366 49372 49374 49376 49378 49380 49382 49384 49386 49388 49390 49392
49394 49396 49398 49500 49503 49506 49509 49512 49515 49516 49517 49518 49519
49521 49524 49525 49527 49530 49533 49534 49536 49542 49544 49548 49551 49554
49564 49565 49569 49570 49572 49574 49576 49578 49580 49582 49584 49586 49590
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49734 49736 49738 49740 49742 49744 49760 49761 49762 49763 49764 49765 49766
49767 49768 49769 49770 49771 49772 49773 49774 49775 49776 49777 49778 49779
49780 49781 49782 49783 49784 49785 49786 49787 49788 49789 49790 49791 49792
49793 49794 49795 49796 49797 49798 49800 49803 49806 49809 49812 49814 49815
49818 49821 49824 49827 49830 49833 49836 49837 49838 49839 49845 49851 49854
49857 49860 49866 49878 49881 49884 49887 49890 50107 50112 50115 50118 50130
50200 50201 50203 50206 50209 50212 50215 50218 50221 50224 50233 50236 50239
50242 50245 50300 50303 50306 50309 50310 50312 50321 50324 50330 50333 50335
50336 50339 50345 50348 50351 50352 50354 50357 50360 50369 50372 50375 50378
50381 50384 50390 50393 50394 50395 50396 50399 50411 50414 50417 50420 50423
50426 50428 50450 50451 50455 50456 50460 50461 50465 50466 50470 50471 50475
50476 50508 50512 50524 50528 50532 50536 50540 50544 50548 50552 50556 50560
50564 50568 50572 50576 50580 50584 50588 50592 50596 50600 50604 50608 50612
50616 50620 50624 50628 50632 50636 50640 50644 50654 50950 50952 51011 51012
51013 51014 51015 51020 51021 51022 51023 51024 51025 51026 51031 51032 51033
51034 51035 51036 51041 51042 51043 51044 51045 51051 51052 51053 51054 51055
51056 51057 51058 51059 51061 51062 51063 51064 51065 51066 51071 51072 51073
51102 51103 51110 51111 51112 51113 51114 51115 51120 51130 51131 51140 51141
51145 51150 51160 51165 51170 51171 51300 51306 51315 51318 91850 91851 91852
91853 91855 91856 91857 91858

Indexation

From 1 July 2023, annual fee indexation will be applied to:

- most of the general medical services items;
- most diagnostic imaging services (but excluding nuclear imaging services); and
- pathology items in Group P12 (74990, 74991, 75861, 75862, 75863 and 75864).

The MBS indexation factor for 1 July 2023 is 3.6 per cent.

Changes to plastic and reconstructive surgery services

From 1 July 2023, there will be changes to plastic and reconstructive surgery services to implement the Government's response to Taskforce recommendations. These changes will:

- Consolidate and restructure some existing items to simplify claiming, to reflect contemporary clinical and surgical practice and for consistency throughout the MBS. Affected areas include burn treatments, breast cancer and reconstruction, cranio-maxillofacial/oral and maxillofacial items, paediatric plastic surgery items.
- Introduce new services for fat grafting for defects arising from breast surgery, breast cancer treatment/prevention and congenital breast deformity.
- Minimise inappropriate cosmetic use of services.

Other changes to general medical services

From 1 July 2023, the following changes will be made to the MBS:

- Cardio-thoracic item 38680 will be amended so that tumour excision services under this item may only be performed in-hospital;
- Orthopaedic item 49706 will be amended to allow patients to access this service where no infection is indicated;
- Therapeutic nuclear medicine item 16015 will be amended to apply to patients with all cancer types;
- Items 13761 and 13762 for extracorporeal photopheresis treatments of graft versus host disease will be amended to apply once per each treatment in a 25-session treatment cycle, rather than once per cycle;
- Increased fees will apply to items 16003, 16006, 16009, 16012 and 16018 to reflect the cost of radiopharmaceuticals used;
- Access to item 32221 for the removal or revision of an artificial bowel sphincter will be extended; and
- Other administrative and machinery changes.

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 Diagnostic Imaging and Pathology (with the exception of items 73384, 73385, 73386 and 73387) 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, 35631, 35632, 35637, 35641, pathology tests (not including pathology items 73384, 73385, 73386 and 73387) 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, 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 Services Australia of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these four items.

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

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

TN.1.5 Intracytoplasmic Sperm Injection - (Item 13251)

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

- where fertilisation with standard IVF is highly unlikely to be successful; or

- where in a previous cycle of IVF, the fertilisation rate has failed due to low or no fertilisation.

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

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

TN.1.6 Peripherally Inserted Central Catheters

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

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

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

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

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

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

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

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

(a) is equipped and staffed so as to be capable of providing to a patient:

(i) mechanical ventilation for respiratory failure for at least 24 hours; and

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

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

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

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

(c) has defined admission and discharge policies.

"immediately available" means that the intensivist must be predominantly present in the ICU during normal working hours. Reasonable absences from the ICU would be acceptable to attend conferences, meetings and other commitments, which might involve absences of up to 2 hours during the working day, provided suitable cover is available. Outside normal working hours the specialist must be immediately contactable and, if required, available to return to the ICU within a reasonable time.

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

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

(a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:

(i) mechanical ventilation for a period of several days; and

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

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

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

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

(c) has defined admission and discharge policies.

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

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

(i) all babies weighing less than 1000gms;

(ii) all babies with an endotracheal tube, and for the 24 hours following endotracheal tube removal;

(iii) all babies requiring Constant Positive Airway Pressure (CPAP) for acute respiratory instability;

(iv) all babies requiring more than 40% oxygen for more than 4 hours;

(v) all babies requiring an arterial line for blood gas or pressure monitoring; or

(vi) all babies having frequent seizures.

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

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

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

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

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

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

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

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

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

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

Item 13839

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

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

Item 13842

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

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

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

Item 13848

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

Items 13851 and 13854

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

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

Item 13857

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

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

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

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

Items 13870 and 13873

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

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

Item 13876

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

Item 11600

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

Item 13899

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

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

Notes:

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

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

(a) the patient either:

(i) is suffering a life-threatening acute illness or injury; or

(ii) is suffering acute illness or injury and, apart from the illness or injury, has a high risk of dying within 12 months;

(b) one or more alternatives to management of the illness or injury are clinically appropriate for the patient;

(c) either:

(i) there is not a record of goals of care for the patient that can readily be retrieved by providers of health care for the patient and that identifies interventions that should, or should not, be made in care of the patient; or

(ii) there is such a record but it is reasonable to expect that, due to changes in the patient's condition, the goals recorded will change substantially.

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

(a) comprehensively evaluating the patient's medical, physical, psychological and social issues;

(b) identifying major issues that require goals of care for the patient to be set;

(c) assessing the patient's capacity to make decisions about goals of care for the patient;

(d) discussing care of the patient with the patient, or a person (the surrogate) who can make decisions on the patient's behalf about care for the patient, and as appropriate with any of the following:

(i) members of the patient's family;

(ii) other persons who provide care for the patient;

(iii) other health practitioners;

(e) offering in that discussion reasonable options for care of the patient, including alternatives to intensive or escalated care;

(f) agreeing with the patient or the surrogate on goals of care for the patient that address all major issues identified;

(g) recording the agreed goals so that:

(i) the record can be readily retrieved by other providers of health care for the patient; and

(ii) interventions that should, or should not, be made in care of the patient are identified.

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

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

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

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

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

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

TN.1.12 Cytotoxic Chemotherapy Administration - (Item 13950)

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

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

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

Phototherapy should only be used when:

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

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

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

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

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

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

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

Entire forehead	50 -75 cm^2
Cheek	55 - 85 cm^2
Nose	10 -25 cm^2
Chin	10 - 30 cm^2
Unilateral midline anterior - posterior neck	60 - 220 cm^2
Dorsum of hand	25 - 80 cm^2

Forearm	100 - 250 cm^2
Upper arm	105 - 320 cm^2

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

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

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

Items 14203 and 14206 are not payable for artificial insemination.

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

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

(a) of cerebral origin; or

(b) due to multiple sclerosis; or

(c) due to spinal cord injury; or

(d) due to spinal cord disease.

Items 14227, 14234 and 14237 should be used in accordance with these restrictions.

TN.1.19 Immunomodulating Agent - (Item 14245)

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

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

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.1.22 Cryopreservation of semen (Item 13260)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Management of Fractures (Items 14270 and 14272)

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

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

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

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

Chemical or Physical Restraints (Items 14277 and 14278)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Intent

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

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

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

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

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

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

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

intravascular;
intramuscular;
subcutaneous;
intrathecal; and
intracavitary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.1.28 Repetitive Transcranial Magnetic Stimulation items 14216, 14217, 14219 and 14220

TN.1.28 Repetitive Transcranial Magnetic Stimulation (rTMS) therapy items (14216, 14217, 14219 and 14220)

Items for Initial course of repetitive transcranial magnetic stimulation (rTMS):

· Item 14216 - prescription and treatment mapping of an initial course of treatment provided by a psychiatrist with appropriate training in rTMS.

· Item 14217 - delivery of an initial course of rTMS treatment of up to 35 sessions provided by, or on behalf of, a psychiatrist with appropriate training in rTMS.

Items for retreatment course of rTMS:

· Item 14219 - prescription and mapping of a retreatment course of rTMS treatment by a psychiatrist with appropriate training in rTMS.

· Item 14220 - delivery of a retreatment course of rTMS treatment of up to 15 sessions provided by, or on behalf of, a psychiatrist with appropriate training in rTMS.

Referral

Referral for item 14216 should be through a GP or a psychiatrist. Where there is an existing therapeutic relationship between the patient and the rTMS-trained psychiatrist, no additional referral is required.

Patient Eligibility

Practitioners should have regard to the relevant diagnostic criteria set out in the International Statistical Classification of Diseases and Related Health Problems – 11th Revision (ICD-11) and the Diagnostic and Statistical Manual of the American Psychiatric Association – Fifth Edition (DSM-5). Major Depressive Disorder is defined as an episode of depression that lasts at least two weeks with marked impairment.

Eligibility for item 14216 requires trialling of each antidepressant medication at the recommended therapeutic dose for a minimum of 3 weeks. While this is the minimum period required, practitioners should have regard to the

RANZCP's clinical guidance, noting trialling of each antidepressant medication at the recommended therapeutic dose for a minimum of 4 weeks (with no response) and 6-8 weeks (where there has been a partial response).

Practice should further be guided by the RANZCP Professional Practice Guidelines for the administration of repetitive transcranial magnetic stimulation.

Where can rTMS services be provided?

While clinical advice indicates that the majority of rTMS services will not require hospital treatment and can be provided on an outpatient basis or in consultation rooms, there will be circumstances where some patients may require hospital treatment. Medicare rebates will apply in both circumstances for eligible patients.

Where rTMS treatment is to be provided as part of hospital treatment (i.e. as an inpatient), the psychiatrist will need to provide written certification that hospital treatment is required for the patient in order for hospital accommodation and other private health insurance benefits to be paid. This is an important requirement under the *Private Health Insurance (Benefit Requirements) Rules 2011* (the Rules).

The rTMS MBS items have a 'Type C' private health insurance procedure classification. Type C procedures are those not normally requiring hospital treatment under the Rules. However, the Rules allow for hospital accommodation and other private health insurance benefits to be paid for Type C procedures if certification is provided.

The medical practitioner (psychiatrist) providing the professional service must certify in writing that, because of the medical condition of the patient or because of the special circumstances specified, it would be contrary to accepted medical practice to provide the procedure to the patient except as hospital treatment in a hospital.

To assist psychiatrists, the Department has published further guidance on the type of information required in a Type C certification on the MBS online website found at MBSonline.

Provider Eligibility and Training Requirements

Providers who can bill these items

These MBS services may only be provided by a psychiatrist, or health care professional on behalf of a psychiatrist, who has undertaken rTMS training.

Prescription and mapping services (items 14216 and 14219) must be personally performed by the psychiatrist trained in rTMS.

Treatment services (14217 and 14220) can be performed by a psychiatrist trained in rTMS, or a health care professional on behalf of the psychiatrist.

Requirements of the health care professional providing rTMS on behalf of the psychiatrist:

A health care professional may include a nurse practitioner, practice nurse or an allied health professional who is trained in the provision of rTMS treatment.

The health care professional performing rTMS treatment services "on behalf of" the psychiatrist should either:

- Be employed by the psychiatrist, or
- Supervised by the psychiatrist, in accordance with accepted medical practice.

It is the responsibility of the prescribing psychiatrist trained in rTMS to ensure that the health professional providing the treatment on behalf of the psychiatrist is appropriately and formally trained in rTMS. Records must be kept to demonstrate that all health care professionals providing rTMS services are appropriately trained.

In line with good practice, the psychiatrist should be available to provide advice as required during treatment and this supervision could be provided from a physician distance (this could be by phone). When rTMS services are provided on behalf the psychiatrist, the psychiatrist continues to remain responsible for planning and monitoring treatment outcomes.

Training requirements

The training requirements for psychiatrists have been endorsed through the Royal Australian and New Zealand College of Psychiatrists (RANZCP). RANZCP-endorsed training courses can be found on the RANZCP website here.

All providers will be subject to ongoing Continuing Professional Development (CPD) requirements set by the RANZCP.

Co-claiming with other items

The following services may be claimed on the same day:

· Prescription and mapping of an initial course of treatment (14216) and the first service in the delivery of treatment (14217).

· Prescription and mapping of a course of retreatment (14219) and the first service in the delivery of retreatment (14220).

MBS item 14217 can be claimed more than once on the same day if deemed clinically appropriate and in line with RANZCP Professional Practice Guidelines.

MBS item 14220 can be claimed more than once on the same day if deemed clinically appropriate and in line with RANZCP Professional Practice Guidelines.

Further Information

Further information about the MBS items and provision of rTMS services is available on the MBS Online website at MBS Online under 'Fact Sheets'. The information on the website may be updated from time to time in response to questions or feedback from providers, patients and other stakeholders.

TN.1.29 Extracorporeal Photopheresis (ECP) for Chronic Graft Versus Host Disease (cGVHD)

For the purpose of administering MBS item 13761 the phrase 'treatment cycle' usually refers to a 12-week time period and item 13762 usually refers to a 6-week time period. A 'treatment session' is an attendance for ECP, which occurs two or three times per week.

A cycle of treatment funded under item 13762 can be preceded by a cycle funded by either item 13761 or by item 13762, provided at least a partial organ response occurs. A response, for the purposes of administering MBS item 13762, is defined as attaining a complete or partial response in at least one organ according to National Institutes of Health (NIH) criteria. A response only needs to be demonstrated after the first 12 weeks of treatment.

Patient Requirements

For the purpose of administering MBS item 13761 and item 13762, steroid-refractory or steroid-dependent disease is defined as one of the following:

a. A lack of response or disease progression after a minimum of prednisone 1 mg/kg/day or equivalent for at least 1 week, OR

b. Disease persistence without improvement despite continued treatment with prednisone at > 0.5 mg/kg/day or 1 mg/kg every day or equivalent other day for at least 4 weeks, OR
c. Increase to prednisolone dose to > 0.25 mg/kg/day or equivalent after 2 unsuccessful attempts to taper the dose.

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, e.g. 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 Services Australia on 132 150.

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

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

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

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

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

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

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

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

TN.4.15 COVID-19 Obstetric MBS Telehealth and Telephone attendance items

COVID-19 MBS telehealth and phone attendance items by obstetricians, general practitioners, midwives, nurse and Aboriginal and Torres Strait Islander health practitioners.

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

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

COVID-19 – TEMPORARY MBS TELEHEALTH ITEMS

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

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

Service	**Existing Items** *face to face*	**Telehealth Items** - *video conference*	**Telephone items** - *for when video conferencing is not available*
Antenatal Service provided by a Nurse, Midwife or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner	16400	91850	91855
Postnatal attendance by an obstetrician or GP	16407	91851	91856
Postnatal attendance by: (i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner	16408	91852	91857
Antenatal attendance	16500	91853	91858

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

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

Restrictions

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

Billing Requirements

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

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

Relevant definitions and requirements

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

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

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

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

The COVID-19 items for a postnatal attendance between 4 and 8 weeks after birth (91851 and 91856) include a mental health assessment of the patient, including screening for drug and alcohol use and domestic violence. A mental health assessment must be offered to each patient, however, if the patient chooses not to undertake the assessment, this does not preclude a rebate being payable for these items.

It is recommended that mental health assessments associated with items 91851 and 91856 be conducted in accordance with the National Health and Medical Research Council (NHMRC) endorsed guideline: Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline – October 2017, Centre for Perinatal Excellence.

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

Technical Requirements

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

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

a. has the capacity to provide the full service through this means safely and in accordance with relevant professional standards; and

b. is satisfied that it is clinically appropriate to provide the service to the patient; and
c. maintains a visual and audio link with the patient; and
d. is satisfied that the software and hardware used to deliver the service meets the applicable laws for security and privacy.

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

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

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

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

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

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

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

Recording Clinical Notes

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

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

Creating and Updating a My Health Record

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

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

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

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

Antenatal Care - (Items 91853 and 91858)

In addition to routine antenatal attendances covered by items 91853 and 91858, the following services, where rendered during the antenatal period, attract benefits:

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

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

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

Items 91850 and 91855 can only be claimed by a medical practitioner (including a vocationally registered or non-vocationally registered GP, a specialist or a consultant physician) where an antenatal service is provided to a patient by a midwife, nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner.

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

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

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

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

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner. The midwife, nurse or Aboriginal and Torres Strait Islander health practitioner must also comply with any relevant legislative or regulatory requirements regarding the provision of the antenatal service. The medical practitioner under whose supervision the antenatal service is provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner is appropriately registered, qualified and trained, and covered by indemnity insurance to undertake antenatal services.

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

The medical practitioner is not required to see the patient or to be present while the antenatal service is being provided by the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner. It is up to the medical practitioner to decide whether they need to consult with the patient. Where a consultation with the medical practitioner has taken place prior to or following the antenatal service, the medical practitioner is entitled to claim for their own professional service, but items 91850 and 91855 cannot be claimed in these circumstances.

Items 91850 and 91855 cannot be claimed in conjunction with another antenatal attendance item for the same patient, on the same day by the same practitioner.

A bulk billing incentive item (10990, 10991 or 10992) cannot be claimed in conjunction with items 91850 and 91855. An incentive payment is incorporated into the schedule fee.

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

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

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

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

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

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

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

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

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

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

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

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

· Bowel resection

· Caesarean section

· Neonatal surgery

· Major laparotomies

· Radical cancer resection

· Major reconstructive surgery e.g. free flap transfers, breast reconstruction

· major joint arthroplasty

· joint reconstruction

· Thoracotomy

· Craniotomy

· Spinal surgery e.g. spinal fusion, discectomy

· Major vascular surgery e.g. 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 e.g. infection and asthma,

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

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

· Anaesthetic problems - e.g. past history of awareness, known or anticipated difficulty with securing the airway, malignant hyperpyrexia, drug allergy,

· Other conditions -

- patients with history of stroke/TIA's presenting for vascular surgery

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

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

NOTE I:

It is important to note that:

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

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

abdominal laparotomy and with recent onset angina with the possible need for ICU postoperatively may require a longer consultation.

NOTE II:

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

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

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

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

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

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

(i) Acute pain management

· Postoperative, utilising specialised techniques e.g. Patient Controlled Analgesia System (PCAS)

· as an independent service e.g. pain control following fractured ribs requiring nerve blocks

· obstetric pain management

(ii) Perioperative management of patients

· postoperative management of cardiac, respiratory and fluid balance problems following major surgery

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

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

NOTE :

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

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

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

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

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.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.

If not stipulated in the item descriptor, 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.

If stipulated in the item descriptor, 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 the block will not attract benefit under the relevant item in Group T7 unless the block has been performed using a targeted percutaneous approach. If the block has been performed using a targeted percutaneous approach this must be noted on the Medicare claim.

When a block is carried out in cases not associated with an operation, such as for 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 - (Items 18230 and 18232)

Items 18230 and 18232 cover caudal infusion/injection.

Item 18230 includes the intrathecal or epidural injection of a neurolytic substance for the palliative treatment of pain.

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 item 18276 covers the provision of regional anaesthesia for surgical and related procedures for the management acute pain or of chronic pain related to radiculopathy. Blockade of lumbar paravertebral nerves should be claimed under 18276. Infiltration of the soft tissue of the paravertebral area for the treatment of other pain symptoms does not attract benefit under this item. Additionally, item 18276 does not cover zygo-apophyseal 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.7.6 Services performed under image guidance (Items 18290, 18292, 18294, 18296, 39013, 39014, 39100)

These services must be performed under image guidance.

Imaging items can be co-claimed with these items when indicated.

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. e.g. 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. e.g. 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 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 note TN.8.4, such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

Extended Medicare Safety Net Cap

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

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

TN.8.3 Procedure Performed with Local Infiltration or Digital Block

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

TN.8.4 Aftercare (Post-operative Treatment)

Definition

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

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

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

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

Private Patients

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

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

There are also some minor operations that are merely stages in the treatment of a particular condition. As such, attendances subsequent to these services should not be regarded as aftercare but rather as a continuation of the treatment of the original condition and attract benefits. Likewise, there are a number of services which may be performed during the aftercare period for pain relief which would also attract benefits. This includes all items in Groups T6 and T7, and items 39013, 39100, 39110, 39014, 39111, 39116, 39117, 39118, 39119, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

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

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

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

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

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

Public Patients

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

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

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

Fractures

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

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

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

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

Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

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

TN.8.5 Abandoned surgery - (Item 30001)

Item 30001 applies when a procedure has commenced, but is then discontinued for medical reasons, or for other reasons which are beyond the surgeon's control (e.g.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 30094 and 30820)

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 30071-30094 and 30820 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 30166, 30169, 30177 and 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 (30166, 30169, 30177 and 30179) for the management of significant weight loss (SWL), SWL is defined as a weight loss equivalent to at least five body mass index (BMI) units. Weight must have been stable for at least six months prior to lipectomy, following SWL.

For SWL that has occurred following pregnancy, the products of conception must not be included in the calculation of baseline weight to measure weight loss against.

The lipectomy items cannot be claimed in association with items 45530, 45531, 45564, 45565 and 45567. Where the abdomen requires surgical closure with reconstruction of the umbilicus following free tissue transfer (45564, 45565, 45567) or breast reconstruction (45530, 45531), item 45571 is to be claimed.

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

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

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

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

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

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

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

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

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

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

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

For Medicare benefits to be payable for item 30196 and 30202, the provider performing the service must also retain documented evidence that malignancy has either been proven by histopathology or confirmed by opinion of a specialist in the specialty of dermatology or plastic surgery.

Guidelines are available on the Department of Health and Aged Care website for what health practitioners can do to substantiate proof of malignancy where required for MBS items.

TN.8.14 Laparotomy and Other Procedures on the Abdominal Viscera - (Items 30622 and 30722)

Procedures on the abdominal viscera may be performed by laparotomy or laparoscopically. Both items 30622 and 30722 cover several operations on abdominal viscera. Where more than one of the procedures referred 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.8.17 Gastrointestinal Endoscopic Procedures - (Items 30473 to 30481, 30484, 30485, 30490 to 30494, 30680 to 32023, 32084 to 32095, 32106, 32232 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.8.19 Anti reflux Operations - (Items 30529 to 30533, 30756 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 (Laparoscopy or laparotomy when an operation is performed on abdominal, retroperitoneal or pelvic viscera, excluding lymph node biopsy, other than a service to which another item in this Group applies).

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

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

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

TN.8.21 Endoscopic or Endobronchial Ultrasound +/- Fine Needle Aspiration - (Items 30688 - 30694, 38416 - 38417)

For the purposes of these items the following definitions apply:

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

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

The provider should make a record of the findings of the ultrasound imaging in the patient's notes for any service claimed against items 30688 to 30694, 38416 and 38417.

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

- A middle aged or elderly patient with a first attack of otherwise unexplained (e.g.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 31388)

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 pigmented lesions which are clinically suspicious for melanoma attracts benefits under items 31377, 31378, 31379, 31380, 31381, 31382 or 31383.

Excision of malignant tumours are covered by items 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371 to 31376, 31386, 31387 and 31388.

Items 31386, 31387 and 31388 should be used for very large, fungating skin cancers.

Items 31357, 31360, 31362, 31364, 31366, 31368, 31370, 31377, 31378, 31379, 31380, 31381, 31382 and 31383 *require* that the specimen be sent for histological examination. Items 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371-31376, 31386, 31387 and 31388 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, except in the case of items 31377, 31378, 31379, 31380, 31381, 31382 or 31383.

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.

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

Practitioners should retain copies of histological reports.

TN.8.23 Removal of Skin Lesion From Face - (Items 31245, 31361 to 31364, 31372, 31373, 31379 and 31380)

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

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

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

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

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

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

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

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

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

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

TN.8.26 Breast Biopsy Items – items 31533 (Fine Needle Aspiration) and 31548 (Mechanical Device Biopsy)

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

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

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

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

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

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

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

TN.8.30 Surgical reversal of a bariatric procedure including revision or conversion surgery (item 31584)

Item 31584 includes the surgical reversal of a previous bariatric procedure and conversion to an alternative bariatric procedure when clinically appropriate.

TN.8.31 Per Anal Excision of Rectal Tumour using Rectoscopy - (Items 32232 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 32232 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 Services Australia provider information line on 132 150 to confirm requirements for correct itemisation of services on a single invoice.

The Department of Health and Aged Care 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 Varicose Vein Intervention

Claiming Guide for the following procedures:

1. Sclerotherapy (Item 32500)
2. Surgical Dissection and Ligation (Items 32507, 32508, 32511, 32514, 32517)
3. Endovenous Laser Therapy (Items 32520 and 32522)
4. Radiofrequency Ablation (Items 32523 and 32526)
5. Cyanoacrylate adhesive (Items 32528 and 32529)

It is recommended that the medical practitioner performing the above procedures has successfully completed a substantial course of study and training in duplex ultrasound and the management of venous disease, which has been endorsed by their relevant professional organisation.

It is recommended that providers familiarise themselves with the symptoms to be used to assess the severity of chronic venous disease as indicated in the item descriptor. Providers should also refer to the latest Clinical impact, Etiology/Aetiology, Anatomy and Pathophysiology (CEAP) classification description for symptoms, to help determine when intervention is required.

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 Services Australia.

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.8.42 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 outpatient settings, consulting suites or offices 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 35637, 35687, 35688, 35691, 37622 and 37623)

(i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (e.g.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 hysterectomy.

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

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

TN.8.51 Ureteroscopy - (Item 36803)

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

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

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

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

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

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

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

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

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

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

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

One of the requirements of item 37220 is that patients have a Gleason score of less than or equal to 7 (Grade Group 1-3). However, where the patient has a score of 7, comprising a primary score of 4 and a secondary score of 3 (ie. 4+3=7; Grade Group 3), it is recommended that low dose rate brachytherapy form part of a combined modality treatment.

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

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

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

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

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

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

TN.8.58 Transcutaneous Sperm Retrieval - (Item 37605)

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

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

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

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

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

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

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

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

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

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

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

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

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

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;
- *electrocardiography (ECG) (items 11704, 11705, 11707, 11714);*
- *echocardiography (items 55126, 55127, 55128, 55129, 55132, 55133, 55134);*
- *continuous ECG recording or ambulatory ECG monitoring (items 11716, 11717, 11723, 11735);*
- *up-right tilt table test (item 11724); and*
- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

TN.8.63 Permanent Cardiac Synchronisation Device (Items 38365 & 38368)

Items 38365 and 38368 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 Services Australia notified of that recognition. The procedure should only be undertaken in a hospital capable of providing cardiac surgery.

TN.8.67 Cardiac and Thoracic Surgical Items - (Items 38470 to 38766, 38817 to 38818)

Items 38470 to 38766 and 38817 to 38818 must be performed using open exposure or minimally invasive surgery which excludes percutaneous and transcatheter techniques unless otherwise stated in the item.

TN.8.70 Skull Base Surgery - (Items 39638 to 39656)

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

Items 39638 to 39656 cover the removal of the tumour, which would normally be performed by a neurosurgeon or an otolaryngology surgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as 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)

Item 41662 is intended to cover the removal of simple nasal polyp or polypi. Simple nasal polyp or polypi are those confined to the middle meatus, the equivalent of Grade 0, 1 or 2 in any accepted clinical nasal polyp grading system.

Item 41668 is intended to cover the removal of nasal polyp or polypi extending beyond the middle meatus, the equivalent of Grade 3 or beyond in any accepted clinical nasal polyp grading system.

Appropriate documentation, ideally with photographic and / or recordings and / or diagnostic imaging evidence demonstrating the grade should be collected and retained to demonstrate the clinical need for the service as this may be subject to audit. Where photographic or diagnostic imaging is not retained, the reasons for this should be clearly documented.

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.8.78 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 purpose of items 45025 and 45026, 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.

Item 45021 covers abrasive therapy only. For the purpose of this item, 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 this item.

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

TN.8.92 Escharotomy - (Item 45054)
Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

TN.8.93 Local Skin Flap - Definition

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

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

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

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

Note: refer to TN.8.126 for MBS item 45202 for circumstances where other services might involve flap repair.

TN.8.95 Revision of Scar - (Items 45510 to 45518)

For the purposes of items 45510 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 45510 to 45518 are only claimable when performed by a specialist in the practice of the specialist's specialty or where undertaken in the operating theatre of a hospital.

Only items 45510 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 - breast volume (45524)

Where volume differences of breasts are referenced, it is expected that volumetric measurement of the breasts is performed using a recognised technique published in a peer-reviewed journal article. Breast volumes and volume differences should be recorded in the patient case notes.

TN.8.97 Breast Reconstruction - Large Muscle or Myocutaneous Flap - (Items 45530 and 45531)

When a prosthesis or prostheses are inserted in conjunction with this operation, benefit would be attracted under Item 45527 or 45529. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a pedicled rectus abdominis flap; item 45571 should be claimed for closure of the abdomen and reconstruction of the umbilicus, including repair of the musculoaponeurotic layer of abdomen. 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.

Lipectomy items 30166, 30169, 30177 and 30179 and radical abdominoplasty items 30175 and 30176 should not be claimed in association with post-mastectomy breast reconstruction items 45530 and 45531.

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, intra-operative photographs of the patient in the supine position need to demonstrate unacceptable deformity in the form of a discrete concavity to justify use of 45553 or 45554.

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

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

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

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

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

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

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

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

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

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

TN.8.101 Liposuction - (Items 45584 and 45585)

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

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

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

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

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

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

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

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

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

Medicare benefits are not payable for non-therapeutic cosmetic services. Full clinical details must be documented in patient notes, including clear photographic evidence of eyelid skin prolapsing over the lashes in a relaxed straight-ahead gaze, causing visual field obstruction. 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 45718)

For the purpose of item 45718, 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 46150 to 46158)

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, e.g. 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 any procedure involving the adjacent 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 46150 to 46158 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.8.111 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 ablation (Item 50952)

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

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

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

Item 42739 should be claimed for patients requiring the administration of anaesthetic by an anaesthetist for the procedure. The administration of oral sedation is not sufficient justification for the use of item 42739, and item 42738 is applicable in those circumstances. Advice from the Royal Australian and New Zealand College of

Ophthalmologists is that independent injections require only topical anaesthesia, with or without subconjunctival anaesthesia, except in specific circumstances as outlined below where the administration of anaesthetic by an anaesthetist may be indicated:

- nystagmus or eye movement disorder;

- cognitive impairment precluding safe intravitreal injection without sedation;

- a patient under the age of 18 years;

- a patient unable to tolerate intravitreal injection under local anaesthetic without sedation; or

- endophthalmitis or other inflammation requiring more extensive anaesthesia (e.g.peribulbar).

GP anaesthetists are expected to meet the Joint Consultative Committee on Anaesthesia (JCCA) Continuing Professional Development (CPD) Standard which defines the minimum recommended requirements for all general practitioners providing anaesthesia services.

Practitioners billing item 42739 must keep clinical notes outlining the basis of the requirement for the administration of anaesthetic by an anaesthetist.

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

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

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

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

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

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

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

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

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

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

TN.8.125 Removal of Skin Lesions - Necessary Excision Diameter - (Items 31356 to 31388)

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 current NHMRC guidelines.

For the purpose of items 31356 to 31388, the defect size is calculated by the average of the width and the length of the skin lesion and an appropriate margin. The necessary excision diameter is calculated as shown in the Factsheet at this link: Determining lesion size for MBS selection

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

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

The initial excision of a suspected melanoma may be claimed using item 31377, 31378, 31379, 31380, 31381, 31382 or 31383, depending on the location of the malignancy and the size of the excision diameter. Wide excision of the primary tumour bed following histological confirmation of 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, 31386, 31387 and 31388, a malignant skin lesion is defined as a basal cell carcinoma; a squamous cell carcinoma (including keratoacanthoma); a cutaneous deposit of lymphoma; or a cutaneous metastasis from an internal malignancy.

TN.8.126 Flap Repair - (Item 45202)

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

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

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

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

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

Eligibility requirements for Item 38276

This item is intended for use in patients where an independent medical practitioner has documented an absolute and permanent contraindication to oral coagulation. The medical practitioner who has documented this contraindication should not have been involved in any decision to provide the service or the actual provision of the service, and is not engaged in the same or a similar group of practitioners.

The following list provides examples of the conditions for which this item is intended:

i. A previous major bleeding complication experienced whilst undergoing treatment with oral anticoagulation therapy without remedial cause, or
ii. History of intracranial, intraocular, spinal, retroperitoneal or atraumatic intra-articular bleeding, or
iii. Chronic, irreversible, recurrent gastrointestinal bleeding of any cause (eg, radiation proctitis, gut angiodysplasia, hereditary haemorrhagic telangiectasia, gastric antral vascular ectasia (GAVE), portal hypertensive gastropathy, refractory radiation proctitis, obscure source), or
iv. Life-long spontaneous impairment of haemostasis, or
v. A vascular abnormality predisposing to potentially life threatening haemorrhage, or
vi. Irreversible hepatic disease with coagulopathy and increased bleeding risk (Child Pugh B and C), or
vii. Receiving concomitant medications with strong inhibitors of both CYP3A4 and P-glycoprotein (P-gp), or

viii. Severe renal impairment defined as creatinine clearance (CrCL) < 15 ml/min or undergoing dialysis and where warfarin is inappropriate, or
ix. Known hypersensitivity to the direct oral anticoagulant (DOAC) or to any of the excipients.

This item is not intended for use in patients with a relative contraindication to oral anticoagulation.

TN.8.133 Endoscopic upper gastrointestinal strictures (item 30475)

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

TN.8.134 Application of items 32084 and 32087

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

TN.8.135 Transcatheter Aortic Valve Implantation (Item 38495)

Items 38495 (high-risk), 38514 (intermediate-risk) and 38522 (low-risk with native calcific aortic stenosis) apply only to a service for Transcatheter Aortic Valve Implantation (TAVI) for the treatment of symptomatic severe aortic stenosis (items 38495 & 38514) and Transcatheter Aortic Valve Implantation (TAVI) for the treatment of symptomatic severe native calcific aortic stenosis, that is to be provided in a TAVI Hospital by a TAVI Practitioner on a TAVI patient.

TAVI Hospital

For items 38495, 38514 and 38522 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 items 38495, 38514 or 38522 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 items 38495, 38514 and 38522 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 items 38495, 38514 and 38522.

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 one of the following:

A. an unacceptably high risk for surgical aortic valve replacement and is recommended as being suitable to receive the service described in item 38495; or
B. has been assessed as having an intermediate risk for surgical aortic valve replacement and is recommended as being suitable to receive the service described in item 38514; or
C. has been assessed as having a low risk for surgical aortic valve replacement (with native calcific aortic stenosis) and is recommended as being suitable to receive the service described in item 38522

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 items 38495, 38514 or 38522 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, item 38514 or item 38522, 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, 38514 or 38522; 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 items 38495, 38514 or 38522. Item 38495, item 38514 or item 38522 are only payable once per patient in a five year period. E.g. if a patient has received a rebate for item 38495 then they cannot receive a rebate for items 38495, 38514 or 38522 for 5 years.

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.

Items 51011 to 51015 should only be used for direct decompression, and not where decompression occurs as an indirect result of the procedure performed. Direct decompression enables the cord and exiting nerve roots to be visualised, and the neural structures decompressed.

Through the anterior approach to the cervical spine, direct decompression can be performed with the resection of the annulus and posterior longitudinal ligament (PLL) and/or uncovertebral joints, the removal of herniated nucleus pulposa (HNP) or osteophytes. In the anterior lumbar interbody space, direct decompression can occur with resection of the posterior annulus and PLL, and removal of the HNP or osteophytes to visualise the cauda equina and decompress the neural structures.

With XLIF and OLIF, decompression can only be indirect.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.8.148 Odontoid Screw fixation – Item 51103

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

TN.8.149 Application of items 51160 and 51166

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

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

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

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

TN.8.151 Mohs surgery service caseload

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

TN.8.152 Colonoscopy Items (items 32222-32229)

Colonoscopy items (items 32222-32229)

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

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

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

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

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

Colonoscopy where a polyp/polyps are removed

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

Definition of previous history (items 32222-32225)

For items 32223-32225 the most appropriate item to be billed is determined by the previous history of the patient.

The previous history for the purpose of these items is defined by number, size and type of adenomas removed during any previous colonoscopy.

Although 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 guidelines 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 Colonoscopy Clinical Care Standard 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
Services Australia 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 Services Australia 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 myGov or the Express Plus Medicare mobile app.

Further information about these services can be found on the Services Australia 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 Health Professional Online Services (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 Services Australia 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 Services Australia website.

TN.8.153 Urology Oncology: Intestinal Conduit - (Items 36600 and 36603)
Patients undergoing these procedures should ideally be treated at a facility adequately resourced for stoma therapy support, where High Dependency Units or Intensive Care Units, experienced nursing staff, and stomal therapy is available.

TN.8.154 Urology Oncology: Nephrectomy and Nephroureterectomy - (Items 36516, 36519, 36522, 36528, 36529, 36531, 36532, 36533 and 36576)
Best practice in treating kidney cancer patients with an estimated glomerular filtration rate (eGFR) $<60ml/min/1.73m^2$ involves multi-disciplinary management in collaboration with a nephrologist.

TN.8.155 Paediatric and reconstructive urology: Pyeloplasty - (Item 36567)
Where laparoscopic surgery is used, this should allow for retroperitoneal as well as abdominal approaches.

TN.8.156 Paediatric and reconstructive urology: Ureterolysis - (Item 36615)
Item 36615 should be used only where there is radiological evidence of obstruction or proximal dilatation of the ureter at surgery. Routine dissection of ureter as part of another operation is not considered ureterolysis for ureteric obstruction.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.8.165 General Urology: Lymph Node Dissection - (Item 37607 and 37610)
Items 37607 and 37610 should be performed using a bilateral template.

TN.8.166 Item 40803 - co-claiming restrictions
Items 39015, 39503, 39906 and 40104 do not apply to a service if the service is provided in conjunction with the service described in item 40803.

TN.8.167 Breast Prosthesis Removal (Item 45551)
Providers should note that 45551 is intended to be claimed when there is a medical indication for performing capsulectomy, such as capsular contracture, presence of a mass within the capsule (seen on pre-operative imaging or intraoperatively) or evidence of Breast Implant Associated Anaplastic Large Cell Lymphoma or other malignancy. If this item is claimed the capsule must be sent for histopathology.

TN.8.168 Procedure for osteotomy (47501, 48400 - 48427)
An osteotomy is a planned bone cut that is intended to realign the bone or alter the length of a bone.

TN.8.169 Procedure for the treatment of unicameral bone cysts (Item 47900)
The item is for the treatment of unicameral bone cysts and is not to be used for the treatment of other cystic lesions of bone such as geodes, subchondral cysts, arthritis associated cysts, or cysts associated with anterior cruciate ligament grafts.

TN.8.171 Procedure for neoplastic mass lesions - intralesional or marginal excision of bone tumor (Items 50203 - 50209)
- The items 50203, 50306 and 50209 are not for removal of a subchondral cyst (geode).
- The items include all aspects of the surgical approach, the resection, and the subsequent reconstruction (as required).
- The resection of a tumour and associated reconstruction includes any neurolysis, arthrotomy, synovectomy, joint stabilisation, ligamentous stabilisation or reconstruction, tendon transfer of any kind, use of any arthroscopic procedure, osteotomy or osteectomy (with or without bone grafting and / or internal fixation), bone grafting (with or without internal fixation), arthroplasty, arthrodesis, internal fixation by any technique, rhizolysis, laminectomy, or spinal fixation, fusion or grafting.

TN.8.173 Procedure for neoplastic mass lesions - wide excision of bone tumor (Items 50212 - 50224)
The histological diagnosis of the aggressive or malignant nature of the tumour should have been previously documented.

TN.8.174 Procedure for neoplastic mass lesions - wide excision of bone tumor (Item 50212)
- The item includes all aspects of the surgical approach, the resection, and the subsequent reconstruction by the same surgeon (as required).
- The resection of a tumour and associated reconstruction includes any bony or soft tissue procedures.
- A second surgeon may claim additional items used in soft-tissue reconstruction associated with tumour resections.

TN.8.175 Procedure for neoplastic mass lesions - wide excision of bone tumor (Items 50215 - 50224)
- The items include all aspects of the surgical approach, the resection, and the subsequent reconstruction by the same surgeon (as required).

- The resection of a tumour and associated reconstruction includes any bony or soft tissue procedures, except for bone grafting items which may be co-claimed where appropriate.
- A second surgeon may claim additional items used in soft-tissue reconstruction associated with tumour resections.

TN.8.176 Procedure for neoplastic mass lesions - amputation (Items 50233 - 50239)

- The histological diagnosis of the aggressive or malignant nature of the tumour should have been previously documented. The item includes all aspects of the surgical approach, the resection, and the subsequent reconstruction by the same surgeon (as required).
- The resection of a tumour and associated reconstruction includes any bony or soft tissue procedures.
- A second surgeon may claim additional items used in soft-tissue reconstruction associated with tumour resections.

TN.8.177 Procedure for bone graft (Items 48245 - 48257)

- Bone grafts may be free, meaning the bone flap is not vascularised which would be considered a free flap or free tissue transfer (item 45562).
- Bone harvested with a vascular pedicle would be referred to as a pedicled bone flap.

TN.8.178 Procedure for bone graft (Item 48257)

'Other graft substitute' does not include demineralised bone matrix or bone graft substitutes such as synthetic materials, ceramics (bone void fillers), collagen composites, composite cement materials, bone morphogenetic protein, or recombinant human bone morphogenetic protein.

TN.8.179 Procedure for removal of internal fixation (Item 47924 - 47929)

- Items 47924, 47927 and 47929 are appropriate to be claimed once per bone.
- Where an implant crosses a joint, or multiple bones, the item should be claimed once, using one of the items, rather than multiple claims of items 47924 and 47927 and 47929.

TN.8.180 Procedure for tendon repair (Item 47954)

For the purpose of item 47954:

1. the service is per tendon if it is the primary procedure; and
2. where a tendon is conjoined or has common origin, it is considered one tendon.

TN.8.182 Procedure for ligament repair, reconstruction and associated intra-articular surgery (Items 49536 and 49542)

- These items are intended to cover all knee ligament repair and reconstruction procedures and associated intra-articular surgery, including (but not limited to), meniscal surgery, notchplasty, chondroplasty and removal of loose bodies.
- Repair is reattachment of a displaced structure and reconstruction is surgery that modifies or augments underlying anatomy. Each item is intended to cover all aspects of the surgery.
- In rare circumstances, patients may require additional osteotomy or patella-femoral stabilisation and in these instances, the relevant item numbers can also be claimed.

TN.8.183 Procedure for arthroscopic knee surgery (Items 49570 - 49590)

- Only a single arthroscopy item for each procedure may be utilised per knee.
- This item must be for the most complex procedure undertaken and must not be utilised in conjunction with any other knee arthroscopy item. Refer to the Australian Orthopaedic Association guidelines for appropriate use.

- Osteoarthritis is a progressive disease involving structural and compositional changes of the whole joint. Multiple clinical trials have demonstrated that knee arthroscopic procedures have no clinically meaningful benefit in patients with uncomplicated osteoarthritis.
- Uncomplicated osteoarthritis is defined as a circumstance where the patient's symptoms or illness are not due to obstructive atraumatic chondral, meniscal or chondral lesions, or repairable menisci, sepsis, neoplasia or inflammatory disorders.
- For patients with uncomplicated osteoarthritis, arthroscopy should only be performed in patients with surgeon-confirmed obstructive symptoms (locked or locking knee), or where the identified pathology is atraumatic chondral, meniscal or chondral lesions that are causative of the symptoms.
- Patient selection for knee arthroscopy in the presence of osteoarthritis should conform to the October 2016 Position statement from the Australian Knee Society on arthroscopic surgery of the knee, including reference to the presence of osteoarthritis or degenerative joint disease, or such standards that supersede these.

TN.8.184 Procedure for synovectomy (Items 46335 and 46340)

Item 46340 is intended to be used at wrist level, while item 46335 is intended to be used distal to the wrist.

TN.8.185 Procedure for synovectomy (Items 46335, 46340 and 46341)

- Procedures 46335, 46340 and 46341, if performed, include tenoplasty, tenolysis, tendon nodules removal, neurolysis and carpal tunnel release.
- The item claimed should be chosen based on the tendons being treated rather than the site of the incision.

TN.8.186 Procedure for neurolysis (Item 39329)

“Extensive” neurolysis should include scar tissue involvement of greater than 5 cm and / or post traumatic adhesions not isolated to a local point of decompression.

TN.8.187 Procedure for pulp re-innervation and soft tissue cover (Item 46504)

- Item 46504 includes all steps of the surgical procedure.
- Reconstruction of the secondary defect by direct closure or a split or full thickness graft is also covered by this item.

TN.8.188 Procedure for reconstruction of nail bed (Item 46489)

'Reconstruction' refers to a late secondary procedure.

TN.8.189 Procedure for nerve transposition (Item 39321)

The item may be claimed in elective or trauma contexts in association with fractures.

TN.8.190 Definitions - Hand and Wrist Items

- **Ray:** From the tip of the digit to proximal metacarpal base of that digit, including phalanges and metacarpal.
- **Index ray:** First web in Dupuytren contracture releases is considered part of the index ray.
- **Primary:** Acute injury and first management of a pathology.
- **Secondary:** Delayed or subsequent to primary treatment, or occurring after normal expected relevant tissue healing time.
- **Vascular graft:** Harvesting of graft, insetting and anastomosis of both ends of graft.
- **Nerve graft:** Harvesting of graft, insetting and neurorrhaphy at both ends of graft.
- **Tendon graft:** Harvesting of graft, insetting and tensioning of graft and tendon weave/repair at both ends of graft.
- **Transcarpal amputation:** Includes the hand through the radiocarpal, midcarpal or carpometacarpal joints.

- **Wrist joint:** Includes radiocarpal, midcarpal and radioulnar joints, which are not to be billed independently.
- **Z-plasty:** Raising, transfer, insetting and suturing of both components (flaps) of the Z-plasty procedure.
- **Flexor tendon:** A tendon on the volar aspect of the digits, hand or wrist.
  – Treatment of only two flexors can be claimed per digit/ray.
  – The two slips of flexor digitorum superficialis (FDS) inserting to the middle phalanx are not to be claimed as two tendons and are to be billed as part of the single FDS tendon.
- **Nerve Trunk:** A bundle of nerve fibers enclosed in a connective tissue sheath.

TN.8.191 Procedure for hip arthroplasty (Items 49372 - 49398)

For the purpose of acetabular bone grafting:

1. Minor bone grafting is intended to cover Paprosky 1 and 2A defects (i.e. minor acetabular derangement / bone loss).
2. Major bone grafting is intended to cover Paprosky 2B, 2C, 3A and 3B defects (i.e. major acetabular derangement / bone loss). Outside of the acetabulum, a major bone graft is considered to be structural in nature, such as a substantive impaction femoral graft, a strut allograft, or equivalent.

TN.8.192 Procedure for adjustment of a fixator (Item 50310)

It is expected that the item 50310 is used in cases where three or more struts or equivalent hardware is adjusted, or in cases where the adjustment of ring fixator or similar device is undertaken with a minimum duration of 30 minutes, in a clinic setting without anaesthetic.

TN.8.193 Procedure for the application or adjustment of a fixator (Item 50300 - 50309)

Each item can only be used once per bone per treatment episode.

TN.8.194 Procedure for the correction of hallux valgus deformity (Items 49821 - 49838)

- Correction of a hallux valgus deformity involves realignment of the joint using soft tissue stabilization and osteotomy of the metatarsal as needed.
- The following items are not to be used on the same joint: arthroscopy (49730 or 49732), bone removal or osteotomy (48430, 48400 or 48403), joint interposition (49821, 49824 or 49783-49788), arthrodesis procedure, ganglion excision, neurolysis (39330), wound debridement (30023) or joint stabilization unless the procedure is performed at a site separate to the 1st metatarsal.

TN.8.195 Procedure for ligamentous stabalisation (Item 49709)

- The item is intended to be claimed once per ligament complex. In most cases, this will correspond to one incision.
- Where multiple incisions are used to access the same ligament complex, this item should only be claimed once.

TN.8.196 Procedure for osteotomy (Items 48400 - 48421 and 48430)

- Removal of prominent bone or osteophytes can be billed as an isolated procedure under 48430 or when through a separate incision to other procedures.
- When an osteotomy is performed through the bone to correct a deformity then the appropriate number is chosen from 48400, 48403, 48406, 48409, 48418 or 48421.
- Not to be used when performing joint arthroscopy (49703, 49730 or 49732), bunion correction (49827, 49830, 49833, 49836, 49837 or 49838), neurolysis (39330), wound debridement (30023) or an arthrodesis procedure unless performed at a site separate to the excluded items.

TN.8.197 Procedure for plantar fascia release (Items 49818 and 49854)

Item 49818 is for simple release of the plantar fascia and item 49854 is for extensive plantar fascia release.

TN.8.199 Definitions - Foot and Ankle Items

- **Ray:** From the tip of a digit to the proximal metatarsal base of that digit, including phalanges and metatarsal bones.
- **Hindfoot joints:** Consist of subtalar, talonavicular and calcaneocuboid joints.
- **Hindfoot bones:** Consist of the calcaneus, talus, navicular and cuboid.
- **Midfoot joints:** Consist of naviculocuneiform and tarsometatarsal joints.
- **Midfoot bones:** Consist of cuneiforms.
- **Major ankle tendons:** Consist of the Achilles', tibialis anterior, tibialis posterior, peroneal (both longus and brevis), extensor hallucis longus and flexor hallucis longus tendons.
- **Flexor tendon:** Both the flexor digitorum longus and flexor digitorum brevis tendons.
- **Extensor tendon:** Both the extensor digitorum longus and extensor digitorum brevis tendons.
- **Reconstruction of a tendon:** Treatment of a degenerative tendon where more than end-to-end repair of tendon rupture is involved.
- **Transtarsal amputation:** Involves amputation of the foot through the tarsal or metatarsal bones, or through the tarsometatarsal joints.
- **Joint debridement:** Removal of osteophytes, removal of part of the joint, and removal of intervening soft tissue, loose bone ossicles or fragments from one or both sides of a joint.
- **Primary treatment:** Acute and first management of an injury or pathology.
- **Delayed or secondary treatment:** Subsequent to primary treatment, or occuring after the normal expected healing time for the relevant tissue.
- **Revision procedure:** A repeat operation to replace or compensate for a failed implant, correct a painful non-union of fracture or fusion, correct malunion, reconstruct a failed soft tissue procedure, or correct undesirable complications of previous surgery.
- **Operative exposure:** Includes (if performed) arthrotomy and/or arthroscopy of joint, washout of joint, removal of loose fragments or loose bodies, synovectomy of neurovascular bundle and closure of capsule.
- **Radical plantar fasciotomy or fasciectomy:** Involves the partial or complete removal of the plantar fascia, but does not involve simple release of the fascia.

TN.8.200 Procedure for arthrodesis

- An arthrodesis consists of joint preparation, removal of surrounding osteophytes, intraarticular joint correction and fixation by any means.
- Bone procedures items (48430, 48400, 48403, 48406, 48409, 48418, or 48421) are not to be claimed unless performed at a separate site to the arthrodesis.
- Neurolysis (39330), wound debridement (30023) and ganglion excision (30107) items are not to be claimed unless performed at a site separate to the arthrodesis site.

TN.8.201 Procedures for excisional and interpositional arthroplasty

- Items for excisional or interposition arthroplasty procedures are indicated for use when items 49734, 48430, 49860, or 49812 do not represent the complete procedure performed.
- Not to be used on the same joint undergoing arthroscopy (49730 or 49732), bunion correction (49827, 49830, 49833, 49836, 49837 or 49838) or an arthrodesis procedure for stabilisation.

TN.8.202 Procedure for arthroscopy (Items 49703, 49730 and 49732)

- Arthroscopy of joint includes associated intraarticular pathology treatment, such as treatment of cartilage, loose bodies, synovectomy, scar removal, and excision of exostosis by arthroscopic means.
- In cases of inflammatory synovitis or osteochondral defect >1.5cm^2, it is appropriate to use item 50312.

TN.8.204 Procedures for tendon transfer (Items 49724 and 49736)

- An adjacent tendon transfer is defined as a side to side repair or transfer of an adjacent tendon to the tendon being reconstructed and covered under 49724.
- When a tendon is harvested from a site separate to the reconstructed tendon or moved to the contralateral side of the foot then item 49736 can be combined.

TN.8.205 Peritonectomy surgery - (item 30732)

Item 30732 (peritonectomy of duration greater than 5 hours, including hyperthermic intra-peritoneal chemotherapy) represents a complete medical service and is inclusive of all procedures performed as part of peritonectomy surgery and chemotherapy. Accordingly, item 30732 cannot be co-claimed with the MBS items for the individual procedures performed as part of the surgery or chemotherapy items.

Note the time requirement for item 30732 refers to operative time only, not overall theatre utilisation time.

On the occasion that peritonectomy surgery is completed in less than 5 hours, and therefore not meeting the item requirements for item 30732, it may be appropriate for relevant individual procedure and chemotherapy items to be claimed, if the requirements of these items are met, with application of the multiple operations rule.

TN.8.206 Exploration of pancreas or duodenum for endocrine tumour (Item 30810)

Extensive exploration includes full surgical exposure of the pancreas with intraoperative ultrasound or endoscopy as required.

TN.8.207 Excision of pilonidal sinus - (item 30676)

Where a fasciocutaneous flap is required to close the pilonidal sinus excision defect item 45203 (single stage local flap to repair defect) can be co-claimed with item 30676.

TN.8.208 Cholangiography and cholecystectomy items (items 30439, 30442, 30445)

An Intraoperative ultrasound of the biliary tract or operative cholangiography (30439) can be claimed in association with a cholecystectomy (item 30448 or 30449).

A choledochoscopy (item 30442) can be claimed in association with a cholecystectomy (30448).

For item 30445 an attempt at cholangiography requires use of a cholangiography catheter and presence of radiography staff and equipment in theatre.

TN.8.209 Procedure for diagnostic biopsy of bone tumor (Items 50200 and 50201)

- Histological proof of either the benign, the aggressive benign, or the malignant nature of the process should be obtained.
- Histological proof may be obtained in conjunction with items 50203, 50206 or 50209. It may be obtained at the time of the procedure (e.g. by intraoperative frozen section analysis of the tumour tissue).

TN.8.210 Eligibility for Paediatric Conditions

This item may be claimed without evidence of right heart overload in highly rare paediatric conditions.

TN.8.211 In and Out of Hospital

Claiming Guidance

- The service to which item 38285 applies may be claimed for the insertion of an implanted loop recorder (ILR) rendered to a patient as part of an episode of hospital treatment, including services provided in hospital outpatient settings.
- Private health insurers are required to pay benefits for products listed on the Prostheses List, if the product is rendered to a patient with the appropriate level of cover, as part of an episode of hospital treatment or hospital substitute treatment.
- When the ILR is inserted in the outpatient setting (the specialist or consultant physicians private rooms/clinic) the private insurer may opt to cover the cost of the device, but is not required to do so.

TN.8.213 Congenital surgery alternative

For congenital surgery, alternative dissolvable options may be used instead of the insertion of permanent fixed rings which may result in negative long term outcomes.

TN.8.214 International guidelines and claiming guide for extraction of leads

International guidelines state that delays from injury to open access to the heart of more than 5–10 minutes are often associated with a fatal outcome. Preparations for this procedure should provide for this rare but life threatening circumstance.

Claiming guide:

When the service to which item 38358 applies is provided to a patient by an accredited **interventional cardiologist** the following claiming will apply:

- Item 38358 is to be claimed by the accredited interventional cardiologist; and
- Item 90300 is to be claimed by the standby cardiothoracic surgeon.

When the service to which item 38358 applies is provided to a patient by an accredited **cardiothoracic surgeon** the following claiming will apply:

- Item 38358 is to be claimed by the accredited cardiothoracic surgeon only

TN.8.215 Discussions of Findings and Abandoned Procedures

Discussions of the results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

Abandoned T8 Surgical Procedures and Selective Coronary Angiography

The new selective coronary angiography items now have time restrictions applied whether claimed by the same or different providers. It is important for the patient that if a provider cannot complete (abandoned) a comprehensive diagnostic angiography that appropriately informs the diagnosis and treatment pathway or is discontinued due to the clinical status of the patient, item 30001 is claimed. This will allow claiming by the provider who subsequently completes the entire diagnostic angiography service taking into consideration the time restrictions for each of the selective angiography items.

TN.8.216 Claiming restrictions to graft patients
Claiming Guidance

This item is only claimable when the patient has graft arteries present and has undergone angiographic investigation of the native coronary arteries and any graft arteries, which can include but is not limited to free coronary grafts attached to the aorta or direct internal mammary artery grafts.

TN.8.217 Staging rules for PCI for acute
Staging

- If a staged procedure is appropriately performed over multiple days, items 38316, 38317 or 38319 must be used for subsequent stages.
- For subsequent stages of an acute percutaneous coronary intervention completed up to 3 months after the initial procedure, it is expected that the patient would receive the subsequent stage/s of the intervention based on the qualifying indication for the initial procedure

Vascular Territories

- The item number claimed should reflect the number of coronary vascular territories (Left Anterior Descending, Circumflex or Right Coronary Artery distribution) that are treated during the procedure, not the total number of treated territories the patient has received to date.
- For isolated Left Main (no involvement of the bifurcation), a single territory should be claimed but if the treated segment involves the bifurcation then 2 territories should be claimed.
- The Intermediate Artery when treated in isolation is single territory, when treated with the Left Anterior Descending or Circumflex or both, should be claimed as two territories.
- A single lesion in a bypass graft should be claimed as single territory regardless of how many vascular territories are supplied by that graft. If the graft has multiple lesions and those lesions are in separate skip portions to a different territory, then an additional territory may be claimed.

TN.8.218 Percutaneous Coronary Intervention (PCI) for stable patients
Stable Angina or Angina Equivalent

- Stable angina or angina equivalent includes chest pain, chest discomfort and/or shortness of breath due to myocardial ischaemia.
- Limiting angina includes patients with symptoms that are Canadian Cardiovascular Society (CCS) class II, III or IV.

Staging

- If a staged procedure is appropriately performed over multiple days, items 38320, 38322 or 38323 should be used for subsequent stages.
- For subsequent stages of a stable percutaneous coronary intervention completed up to 3 months after the initial procedure, it is expected that the patient would receive the subsequent stage/s of the intervention based on the qualifying indication for the initial procedure

Coronary Vascular Territories

- The item number claimed should reflect the number of coronary vascular territories (Left Anterior Descending, Circumflex or Right Coronary Artery distribution) that are treated during the procedure, not the total number of treated territories the patient has received to date.
- The number of coronary vascular territory refers to any of the 3 major arteries (Left Anterior Descending, Circumflex or Right Coronary Artery) or their branches. The item number claimed should reflect the

number of coronary vascular territories that are treated during the procedure, not the total number of diseased territories.

- For isolated Left Main (no involvement of the bifurcation), a single territory should be claimed but if the treated segment involves the bifurcation then 2 territories should be claimed.
- The intermediate artery when treated in isolation is considered a single territory, however when treated with the Left Anterior Descending or Circumflex or both, it can be claimed as two territories.
- A single lesion in a bypass graft should be claimed as a single territory regardless of how many vascular territories are supplied by that graft. If the graft has multiple lesions and those lesions are in separate skip portions to a different territory, then an additional territory may be claimed.

TN.8.219 Complex coronary artery disease definition

Complex Coronary Artery Disease

Complex coronary artery disease is defined as

a. a stenosis >50% in the left main coronary artery; or
b. >90% in the proximal left anterior coronary artery; or
c. bifurcation lesions involving side branches with a diameter >2.75mm; or
d. chronic vessel occlusions (>3 months); or
e. severely angulated or severely calcified lesions; or
f. SYNTAX score >23.

Such disease should only undergo PCI with a documented recommendation from a Heart Team Conference.

TN.8.220 Co-claiming a consultation for Paediatric patient

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

TN.8.221 Paediatric conditions exemption

Claiming Guidance

This item may be claimed without evidence of right heart overload in highly rare paediatric conditions such as abnormal development of the right heart. Additionally, in patients under 16 years old, risk of paradoxical embolism is sufficient.

TN.8.222 Indications for Percutaneous transluminal coronary rotational atherectomy

Percutaneous transluminal coronary rotational atherectomy is suitable for revascularisation of stenoses in heavily calcified coronary arteries in the absence of significant lesion angulation or vessel tortuosity in patients for whom coronary artery bypass graft surgery is not indicated.

Item 38309 describes an episode of care and can only be claimed once in a single episode.

TN.8.223 Procedures for stabalisation (Items 49734, 48400, 48403, 49809 and 49812)

- Items for stabilisation of a joint procedure are indicated for use when items 49734, 48400, 48403, 49809 or 49812 do not represent the complete procedure performed.
- Not to be used on the same joint undergoing arthroscopy (49730 or 49732), bunion correction (49827, 49830, 49833, 49836, 49837 or 49838) or an arthrodesis procedure for stabilisation.

TN.8.224 Procedure for revision arthrodesis (Item 49776)

Item 49776 is claimable once per joint.

TN.8.225 Percutaneous Coronary Intervention (PCI) Acute/Unstable

Staging of acute/unstable PCI

- Staging of acute PCI is permissible when clinically appropriate.
- An example of appropriate Acute Coronary Syndrome (ACS) staging could include intervention on an occluded proximal lesion in the context of an ST elevation myocardial infarction (STEMI) and a decision is made not to intervene on a distal lesion as it is difficult to determine whether it is a real lesion (possibly a thrombus) or the patient's haemodynamic status remains compromised (clinically unsafe to continue).

Requirements of subsequent stages of a staged acute/unstable PCI

- The qualifying indication for the initial procedure is to be used as the qualifier for the relevant subsequent stages.
- Subsequent stages are required to be completed within 3 months of the initial procedure otherwise the patient will need to requalify under the appropriate indication (if applicable).
- It would generally be expected that subsequent stages would be completed as soon as is practicable proceeding the initial intervention.
- For subsequent stages of an acute/unstable PCI it is implied that diagnostic angiography has been completed in the previous 3 months and therefore it is only permissible to claim items 38316, 38317 or 38319 for subsequent stages.

Multiple Providers of one episode of care (acute/unstable or stable) PCI – Separate interventional sites or Same interventional site

One of the primary intentions of the changes to selective coronary angiography and PCI items, is to encourage the provision of the entire intervention in a single episode of care. Therefore, the provider should consider that there will be a reasonable need to intervene (revascularise), noting that in some cases intervention is not required (e.g. pressure testing – FFR result does not support the need for stenting).

However, it is recognised that some providers of interventional cardiology services only provide selective coronary angiography (diagnostic) and require a secondary provider to undertake angioplasty, stenting and/or atherectomy.

Non-interventional – selective angiography providers (clinical assessment suggests intervention required)

Acute/Unstable patients

- Acute/Unstable patients should undergo both selective coronary angiography and PCI by an accredited PCI provider in a single episode of care, unless staging is clinically required.
- Rare exceptions might include rural or remote sites that offer diagnostic angiography as a triage service prior to limited availability PCI.
- It would be expected that the non-interventional cardiologist (non-PCI accredited) has a limited role in the management of acute/unstable patients.

Separate hospital/procedural sites (Acute/Unstable or Stable)

- The first provider undertakes the diagnostic angiography and either makes an independent decision or following discussion with the interventional cardiologist refers to the secondary provider at another site for the purposes of revascularisation (e.g. referral from a rural or regional hospital to a metropolitan hospital); therefore
- In this scenario there is a clear delineation between the angiography and revascularisation services due to the different geographical locations (separate episodes of care). Example claiming is as follows:

Acute (ACS) - claiming example

- Provider 1 – site 1 (diagnostic angiography) claims item 38244 (ACS – selective angiography). Provider 2 – site 2 (PCI) claims item 38316 (ACS – PCI single territory)

Abandoned T8 Surgical Procedures and Acute or Stable Percutaneous Coronary Intervention (PCI) – Excluding appropriate staging

The new acute PCI items have time restrictions applied whether claimed by the same or different providers. It is important for the patient that if a provider cannot complete (abandoned) the PCI and rescue PCI needs to be conducted by another provider, item 30001 is claimed. This will allow claiming by the provider who subsequently completes the rescue PCI, taking into consideration the time restrictions for each of the selective angiography items.

The new stable PCI items do not have time restrictions. However, it is important for the patient that if a provider cannot complete (abandoned) the PCI and rescue PCI needs to be conducted by another provider, item 30001 is claimed. This will allow claiming by the provider who subsequently completes the rescue PCI, taking into consideration the time restrictions for each of the selective angiography items.

TN.8.226 Staging Rules for Stable PCI

Staging of non-acute (stable) PCI

- Staging of stable PCI is permissible when clinically appropriate. An example of appropriate stable staging could include intervention on the primary target lesion and a decision is made not to intervene on secondary lesions (in triple vessel disease) due to the patient's deteriorating haemodynamic status (clinically unsafe to continue).

Requirements of subsequent stages of a staged stable PCI

- The qualifying indication for the initial procedure is to be used as the qualifier for the relevant subsequent stages. Subsequent stages are expected to be completed within a reasonable time period following the initial intervention.
- For subsequent stages of a stable PCI it is implied that diagnostic angiography has been completed in the previous 3 months and therefore it is only permissible to claim items 38320, 38322 or 38323 (standalone PCI items) for subsequent stages.
- **Note:** For patients who meet the criteria in subclause (2)(b) of note TR.8.4 in 3 vascular territories (triple vessel disease), whether treated in an initial procedure (items 38314 or 38323) or in subsequent stages (items 38311, 38313, 38320 or 38322) it is expected that the patient must meet the criteria for (2)(b) of note TR.8.4 for each territory for each subsequent stage. This requirement ensures that the patient who has triple vessel disease must meet the criteria for (2)(b) for each territory when staged or completed in an initial procedure.

The Department will be closely monitoring claiming patterns for staged procedures, particularly where volumes for staged procedures at the same site are not consistent with the broader provider claiming base.

Multiple Providers of one episode of care (stable) PCI – Separate interventional sites or Same interventional site.

One of the primary intentions of the changes to selective coronary angiography and PCI items, is to encourage the provision of the entire intervention in a single episode of care. Therefore, the provider should consider that there will be a reasonable need to intervene (revascularise), noting that in some cases intervention is not required (e.g. pressure testing – FFR result does not support the need for stenting).

It is recognised that some providers of interventional cardiology services only provide selective coronary angiography (diagnostic) and require a secondary provider to undertake angioplasty, stenting and/or atherectomy.

Non-interventional – selective angiography providers (clinical assessment suggests intervention required)

Stable patients

It is accepted clinical practice that the following patient pathways for stable PCI service provision (other than a complete service by an accredited PCI cardiologist) may occur when considering the role of the non-interventional cardiologist (non-PCI accredited) as follows:

Ad-hoc PCI:

- Provider 1 completes the selective angiography and hands over to provider 2 to perform the PCI while the patient is still on the cardiac catheterisation table with the arterial access still in place.
- Similar to the acute items, this scenario would likely be rare for e.g. dissection of a coronary artery caused by the angiography catheter that may convert the patient from stable to unstable.
- It is current accepted practice that the selective coronary angiography component of the service can be performed by a non-interventional cardiologist and the PCI component (when required) completed by a PCI accredited provider.
- Ideally ad-hoc stable PCI should be completed by a PCI accredited provider and therefore consideration should be given to current practice site arrangements going forward.

Delayed PCI:

- Provider 1 completes ICA and refers the patient to provider 2, who performs the PCI later on the same day.
- In the stable patient this scenario presents the opportunity to pause and consider whether optimal medical therapy, PCI or coronary artery bypass may be the preferred option in consultation with a PCI accredited cardiologist and/or cardiothoracic surgeon; and
- It also allows for a further opportunity to obtain informed consent from the patient for the proposed intervention.
- In most cases this would involve maintaining the arterial access with an indwelling arterial sheath to avoid repuncture.

Elective PCI:

- Provider 1 completes ICA and refers the patient to provider 2, who performs the PCI on the next day, or any subsequent day.
- Similar to delayed PCI, however the PCI accredited cardiologist may not be available on the same day as when the selective coronary angiography was completed; or
- A short trial of optimal medical therapy is recommended; or
- Further non-invasive functional testing is recommended.

The Department will be closely monitoring claiming patterns, particularly at the same site where selective angiography is completed by a non-accredited cardiologist and the PCI component completed by a PCI accredited provider.

The following provides guidance for when the provider can only undertake the selective angiography component of a complete PCI service (PCI non-accredited provider):

Separate hospital/procedural sites (Stable)

The first provider undertakes the diagnostic angiography and either makes an independent decision or following discussion with the interventional cardiologist refers to the secondary provider at another site for the purposes of

revascularisation (e.g. referral from a rural or regional hospital to a metropolitan hospital). In this scenario there is a clear delineation between the angiography and revascularisation services due to the different geographical locations (separate episodes of care). Example claiming is as follows:

- Stable - example
  Provider 1 – site 1 (diagnostic angiography) claims item 38248 stable – selective angiography). Provider 2 – site 2 (PCI) claims item 38320 (stable – PCI single territory)

Same hospital/procedural site (Stable)

- The first provider undertakes the diagnostic angiography and either makes an independent decision or following discussion with the interventional cardiologist requesting that the secondary provider undertakes the revascularisation component.
- Please note that the underlying intention of a complete PCI service is that the entire service, including diagnostic angiography is completed by a single provider where possible.

Abandoned T8 Surgical Procedures and Acute or Stable Percutaneous Coronary Intervention (PCI) – Excluding appropriate staging

The new acute PCI items have time restrictions applied whether claimed by the same or different providers. It is important for the patient that if a provider cannot complete (abandoned) the PCI and rescue PCI needs to be conducted by another provider, item 30001 is claimed. This will allow claiming by the provider who subsequently completes the rescue PCI, taking into consideration the time restrictions for each of the selective angiography items.

The new stable PCI items do not have time restrictions. However, it is important for the patient that if a provider cannot complete (abandoned) the PCI and rescue PCI needs to be conducted by another provider, item 30001 is claimed. This will allow claiming by the provider who subsequently completes the rescue PCI, taking into consideration the time restrictions for each of the selective angiography items.

TN.8.227 Vertebroplasty MBS Service Monitor (item 35401)

For item 35401 practitioners should be registered with and provide relevant service data to the Vertebroplasty MBS Service Monitor, managed by the Interventional Radiology Society of Australasia (IRSA).

IRSA can be contacted via e-mail at secretariat@irsa.com.au for enquiries.

TN.8.228 Varicose Vein Intervention and Proximal Reflux (item 32500)

Claiming Guide for the following procedures:

1. Sclerotherapy (32500)
2. Surgical Dissection and Ligation (Items 32507, 32508, 32511, 32514, 32517)
3. Endovenous Laser Therapy (Items 32520 and 32522)
4. Radiofrequency Ablation (Items 32523 and 32526)
5. Cyanoacrylate adhesive (Items 32528 and 32529)

It is recommended that the medical practitioner performing the above procedures has successfully completed a substantial course of study and training in duplex ultrasound and the management of venous disease, which has been endorsed by their relevant professional organisation.

It is recommended that providers familiarise themselves with the symptoms to be used to assess the severity of chronic venous disease as indicated in the item descriptor. Providers should also refer to the latest Clinical impact, Etiology/Aetiology, Anatomy and Pathophysiology (CEAP) classification description for symptoms, to help determine when intervention is required.

Definition of Proximal Reflux (item 32500)

For the purposes of item 32500, proximal reflux can include: truncal, perforating or other sources of ultrasound demonstrated reflux into the vein/s being treated.

TN.8.229 Appropriate Documentation

Appropriate documentation, ideally with photographic and/or histological evidence, is to be collected and retained to demonstrate the complexity of the procedure performed. Where photographic evidence is not retained, the reasons for this should be clearly documented.

TN.8.230 Hydrotubation (Item 35703)

It is expected that this item should only be billed once per patient per lifetime unless clinically indicated in cases where a successful pregnancy has been achieved following hydrotubation of fallopian tubes or another intervening and documented condition has occurred such a tubal infection, an episode of surgery or conservative treatment of an ectopic pregnancy.

TN.8.231 Hysterectomy (Items 35750, 35751, 35753, 35754, 35756)

Procedure may be undertaken using laparoscopy with any number of ports or by any approach as clinically indicated.

A laparoscopically assisted vaginal hysterectomy is defined as the introduction of the laparoscope to assess the pelvis and commence the procedure taking the round ligaments, adnexal attachments as indicated and to the level of the uterine arteries with the uterine arteries and uterosacral pedicles secured vaginally.

A total laparoscopic hysterectomy is defined as the introduction of the laparoscope to assess the pelvis and complete the procedure laparoscopically including securing the uterine arteries and uterosacral pedicles.

The complex hysterectomy items 35753 and 35754 are intended to cover procedures with increased complexity. 35753 is to be used for the excision of moderate endometriosis. 35754 is to be used for the excision of extensive endometriosis and when side wall dissection is required.

TN.8.232 Documentation collection

Appropriate documentation is to be collected and retained to demonstrate the complexity of the procedure performed.

TN.8.233 National Cervical Screening Program

The procedure should only be performed if a patient satisfies the criteria according to the current National Cervical Screening Program.

TN.8.234 Cervical ablation (Item 35644 and 35645)

- Not for use in patients with a type 3 transformation zone.

- A second ablative treatment for a HSIL (CIN2/3) should NOT be performed (an excisional treatment is indicated in this situation).

- Treatment of high-grade lesions (CIN 2/3) in an immunocompromised patients should be by excisional methods only.

TN.8.235 Gynaecological Oncologist or MDT Review

If the procedure is for glandular high grade abnormality or any suspected invasive cancer the procedure should be performed by a gynaecological oncologist or only after discussion with, or review by, a gynaecological oncologist or gynaecological oncology multidisciplinary team (MDT).

TN.8.236 Radical Debulking with abdominal cavity involvement (Item 35721)

This procedure should be undertaken by a person with appropriate training in line with the National Framework for Gynaecological Cancer Control.

This item includes the extensive dissection and removal of the peritoneum from organs contained in the abdominal/pelvic cavity, including bowel, bladder, spleen, pancreas or liver.

This item does not include resection of bowel, bladder, spleen, pancreas or liver.

This item should not be used for staging procedures for gynaecological malignancy.

This item should not be used for a lymph node recurrence without involvement of peritoneal surfaces.

TN.8.237 Excision of benign vaginal tumours (Item 35557)

This item should not to be used for the sole purpose of vaginal biopsy, drainage or Gartner duct cysts, cautery of granulation tissue, or removal of vaginal polyps.

Item 35615 should be used for vaginal biopsies.

Item 35611 should be used for vaginal polyp removal.

TN.8.238 Partial Vaginectomy (Item 35548)

This item not to be used for vaginal biopsy or polypectomy.

Item 35615 should be used for vaginal biopsies.

Item 35611 should be used for vaginal polyp removal.

TN.8.239 Radical Vulvectomy (Item 35548)

Co-claiming with a relevant flap procedure is permitted. However, deep tissue mobilisation is included in this item.

TN.8.240 Intra-articular injection (Item 39013)

This service must be performed under image guidance. Imaging items can be co-claimed with item 39013 when indicated.

Where intra-articular zygapophyseal joint injection provides a short term effect that is repeatedly observed, consideration should be given to longer lasting pain management techniques.

TN.8.241 Placement of peripheral nerve leads for the management of chronic intractable neuropathic pain (Items 39129 and 39138)

Items 39129 and 39138 are for the insertion of leads that are intended to remain in situ long term. Percutaneous Electrical Nerve Stimulation (PENS) is not to be claimed under these items.

The use of PENS for the management of chronic pain has not been assessed by the Medical Services Advisory Committee (MSAC) or recommended for public funding. Therefore, PENS procedures for management of chronic pain cannot be billed under the MBS, including items 39129 and 39138.

Item 39138 is the appropriate item to claim when surgical lead placement is required for a trial procedure prior to longer term placement. Item 39129 is the appropriate item for the percutaneous placement of leads, including for trial procedures.

Items 39129 and 39138 provide for the insertion of one or multiple leads. There is no intention to change current billing practices for these items, e.g. where more than one lead may be billed as part of an episode.

TN.8.244 Implanted device items

As with all interventions, implant procedures should be performed in the context of clinical best practice. This is of particular importance given the high cost of the devices. Current clinical best practice for use of these item numbers includes:

- All procedures being performed in the context of a comprehensive pain management approach with a multidisciplinary team.

- Patients should be appropriately selected for the procedure, including, but not limited to assessment of physical and psychological function prior to implantation with findings documented in the medical record.

- Outcome evaluation pre and post implantation.

- Appropriate follow up and ongoing management of implanted medical devices should be ensured.

Implantable devices require ongoing monitoring and management. If the person providing the implantation service is not the ongoing physician manager of the device, they are responsible for ensuring that appropriate ongoing management has been arranged.

Items 39130 and 39139 provide for the insertion of one or multiple leads. There is no intention to change current billing practices for these items, e.g. where more than one lead may be billed as part of an episode.

Item 39133 can be billed twice per attendance where services are separate procedures. Accompanying text is required for these claims such as one item is for the removal of an infusion pump and one item is for the removal or repositioning of a spinal catheter.

TN.8.245 Percutaneous denervation (Items 39110, 39111, 39116 to 39119, 39323)

In the majority of circumstances, thermal radiofrequency should be the modality of choice. Pulsed radiofrequency should only be used in limited cases, such as when an anatomic abnormality precludes the correct positioning of a thermal radiofrequency probe.

Prior to commencing treatment, the patient should be made aware of:

(a) which modality is being used and why;

(b) what longevity of response is expected;

(c) the mechanism involved;

(d) technical details such as the temperature used;

(e) the evidence base for the modality recommended; and

(f) cost

Clear distinctions should be made between thermal (continuous) radiofrequency neurotomy and pulsed radiofrequency of the medial branch of the dorsal rami of spinal nerves for treatment of zygapophyseal pain.

Items 39110, 39111, 39116, 39117, 39118, 39119

There are six MBS items applicable to percutaneous neurotomy (items 39110, 39111, 39116, 39117, 39118 and 39119). The items relate to six regions of the spine (lumbar, thoracic, and cervical divided into left and right sides). These items commenced on 1 March 2022.

Effective 11 April 2022, there are new frequency claiming restrictions for these items.

A patient can now receive percutaneous neurotomy treatment in up to three episodes of care in a 12-month period. An episode of care means one or more percutaneous neurotomy services performed in a single attendance, where clinically relevant.

The percutaneous neurotomy items are claimable per joint treated, not per nerve or lesion.

For compliance purposes, practitioner should record the name of the joint/s that are being treated during an attendance in the patient's clinical notes.

More than one joint in the same region can be treated and claimed on the same day (i.e. as part of the same episode), and joints in another region can also be treated in the same episode.

The Multiple Operation Rule will continue to apply when more than one joint is being treated in the same episode.

The 12-month period is a rolling period, commencing on the date of the first episode (for treatment provided on or after 11 April 2022), to a maximum of three episodes over the next 12 months. For example, if the first episode of treatment is provided on 20 April 2022, up to two further episodes of treatment can be provided up to 19 April 2023.

Treatment provided under these items from 1 March 2022 to 10 April 2022 (inclusive) will not be counted in the 12-month period for the patient.

Treatment of the T12/L1 zygapophyseal joint should be classified as a thoracic region procedure. Accordingly, the thoracic items 39116 or 39117 would be appropriate for such a procedure.

The C7/T1 facet joint is innervated by the medial branches of C7 and C8 (cervical region). Accordingly, the relevant cervical items 39118 or 39119 would be appropriate for such a procedure.

Item 39323

Item 39323 is limited to 6 services for a given nerve per 12-month period. The 12-month period will start from the first time the item has been claimed on or after 1 March 2022 and will continue on a rolling 12-month basis.

For compliance purposes, the applicable nerve name must be documented in the patient record and noted on Medicare claims for item 39323 e.g. '39323 - Right Genicular nerve.'

TN.8.246 Rectal Resection (items 32025, 32026 and 32028)

These rectal resection procedures should be performed with the following requirements:
- in an appropriate setting with High Dependency Unit or Intensive Care Unit availability;
- include multidisciplinary team discussion of patient;
- have patient managed using Enhanced Recovery after Surgery (ERAS) principles; and
- in a setting with adequate access to stomal therapy nurse services.

In addition, item 32028 is appropriately used by 1 surgeon incorporating transanal total mesorectal excision.

TN.8.247 Faecal incontinence management items (32213, 32216 and 32237)

These services may be performed using fluoroscopic guidance.
The relevant fluoroscopic guidance item can be co-claimed with items 32213, 32216 and 32237 when indicated.

TN.8.248 Endometriosis classification system

For the purposes of any item in which an endometriosis grading is referenced the equivalent grade under the American Fertility Society (rAFS) endometriosis classification system is as follows:
Minimal endometriosis is the equivalent of stage I.
Mild endometriosis is the equivalent stage II.
Moderate endometriosis is the equivalent to stage III.
Servere endometriosis is the equivalent stage IV or higher.

TN.8.249 Hysteroscopy (Items 35633 and 35635)

For the purposes of item 35633, minor intrauterine adhesions means Grade 1 under the European Society for Hysteroscopy (ESH) classification system. For the purposes of item 35635, moderate to severe intrauterine adhesions means Grade 2 or higher under the ESH classification system.

TN.8.250 Multi-disciplinary team for cryoablation for renal cell carcinoma

For the purpose of item 36530, a multi-disciplinary team typically includes a urologist, interventional radiologist and oncologist. Patients eligible for Medicare-funded cryoablation need to be considered by the multi-disciplinary team as not suitable for partial nephrectomy and typically have one or more of the following characteristics:

- Elderly and/or frailty;
- High surgical risk;
- Poor renal function;
- Solitary kidney;
- Bilateral kidney tumours.

TN.8.251 Interventional radiologist for renal cell carcinoma cryoablation

For the purpose of item 36530, the procedure is to be performed by an interventional radiologist specially trained for the procedure. Percutaneous cryoablation should be the preferred approach unless the percutaneous approach is considered not suitable for the individual patient by the multi-disciplinary team.

TN.8.252 Circumcision Revision items (items 30661 and 30662)

Items 30661 and 30662 provide for clinically relevant revision surgery following a circumcision procedure (performed on a previous occasion).

A minor repair procedure (item 30661) would apply to the removal of redundant skin, or the correction of minor scarring where there is a clinical need for revision.

A major repair (item 30662) applies to the correction of major scarring where there is a deformity, pain, significant loss of tissue or functional disability.

TN.8.253 Reprogramming of a neurostimulator for the treatment of chronic pain or pain from refractory angina pectoris (items 39131 and 39141)

Items 39131 (in person service) and 39141 (remote service by video conference) provide for the reprogramming of an implanted neurostimulator when this has been deemed clinically relevant for the care of a patient by the treating practitioner.

Item 39131 should be billed if the medical practitioner attends in person, and item 39141 should be billed if the medical practitioner attends remotely by video conference. Item 39141 cannot be provided by phone. Only one service can be billed for a patient on a particular day.

Items 39131 and 39141 should not be billed with each other on the same day, or with another attendance item on the same day unless the consultation pertains to a condition other than chronic neuropathic pain, or pain from refractory angina pectoris.

TN.8.254 Parotid gland surgery - (Items 30247 - 30253)

Exposure of the facial nerve and the great auricular nerve with or without mobilisation are considered integral parts of parotid gland surgery and hence part of the complete procedure for items 30247, 30250, 30251 and 30253. As such, co-claiming of items 39321, 39324, 39327, 39330 is not appropriate.

TN.8.255 Otology - (Item 41647)

Item 41647 applies where use of an operating microscope or endoscope is clinically necessary, such as where examination by conventional means (hand-held or spectacle-mounted auroscope) does not provide sufficient detail.

In addition, item 41647 cannot be claimed for the removal of uncomplicated wax in the absence of other disorders of the ear.

The removal of uncomplicated wax in the absence of other disorders of the ear by operating microscope or endoscope, or the removal of wax by microsuction or syringing using any visualisation method may be claimed as part of an MBS general attendance item provided all other requirements of the item have been met.

TN.8.256 Rhinology - (Items 41707 and 41725)

It is not expected that this item would be claimed with routine endoscopic sinus surgery procedures. It may be legitimately claimed in some advanced sinonasal or tumour procedures.

TN.8.257 Rhinology - (Item 41764)

Item 41764 can be performed on a patient by an eligible speech pathologist on behalf of a specialist in the speciality of otolaryngology head and neck surgery, if:

(a) the service is performed following a written request made by the specialist to assist the specialist in the diagnosis, treatment or management of a laryngeal condition or related disorder in the patient; and

(b) the service is performed in a medical facility; and

(c) the service is performed on the patient individually and in person; and

(d) after the service is performed, the eligible speech pathologist gives the specialist:

(i) recorded dynamic images of, and a copy of the results of, the service; and

(ii) relevant written comments, prepared by the eligible speech pathologist, about those results; and

(e) a service to which item 41764 applies has not been performed on the same patient on the same day.

For the purposes of item 41764, a medical facility may include medical or allied health consulting rooms, hospitals (including outpatient clinics and wards), community health facilities, and residential aged care facilities (as defined in the Aged Care Act 1997).

TN.8.258 Laryngology - (Items 41837 and 41840)

Items 41837 and 41840 may be claimed for both open procedures and endoscopic equivalents. In the case of endoscopic procedures, it is required that the extent of the resection be anatomically equivalent to open procedures excepting resection of thyroid cartilage. This item can only be claimed once per provider, per patient per lifetime.

TN.8.259 Repair or radical correction of pectus excavatum or pectus carinatum

Item 38846 - **Repair or radical correction of pectus excavatum or pectus carinatum**

Where the repair or correction of the condition requires the insertion of a device, the insertion of the device is included in the procedure.

TN.8.260 Plating of ribs

Item 38859 - **Plating of ribs**

This item allows for the plating of multiple ribs for flail segment in the circumstance of failure to wean from mechanical ventilation. Internal fixation of a single rib can be performed under item 48409.

TN.8.261 Radical excision of intra-oral tumour - (Item 30275)

Item 30275 only applies when both an intra-oral resection and a lymph node dissection are performed during the same procedure. The procedure may, or may not, include the resection of the mandible.

TN.8.262 Revision of Breast Prosthesis Pocket – (Item 45547)

Item 45547 provides for the reinsertion of an existing prosthesis and not for insertion of a new prosthesis. Items 45553 and 45554 provide for the removal of a prosthesis and replacement with a new prosthesis.

TN.8.263 Terminology for Vascular Anomalies – (Items 45027 to 45045)

For further guidance on terminology used for vascular anomalies, providers are encouraged to consult the classification of the *International Society for the Study of Vascular Anomalies (ISSVA)* 2018 at https://www.issva.org/classification.

Where a haemangioma has been medically treated and there is only a residuum present, the appropriate MBS item should relate to the size of the residuum and not the size of the original haemangioma.

TN.8.264 Terminology for “maxilla” – (Items 45596 and 45597)

Historically, the term “maxilla” referred to one of the two identical bones that form the upper jaw with the “maxillae” meeting in the midline of the face. Currently the “maxilla” is considered a double structure or one bone (i.e. the entire upper jaw).

A “hemimaxillectomy” refers to the surgical removal of one side of the upper jaw while a “total maxillectomy” refers to the removal of all of the “maxilla” (i.e. both sides). For item 45597, the term "bilateral" will be included in recognition that some practitioners still conduct their practice using the historical terminology, however, it is expected that most providers will use the current terminology.

TN.8.265 Oncoplastic Breast Surgery – (Items 31513 and 31514)

For guidance, item 31513 provides for simple oncoplastic breast surgery using simple glandular flaps, while item 31514 provides for breast reduction and/or mastopexy techniques to reshape the breast.

TN.8.266 Free Grafting - Split Skin and Full Thickness - (Items 45440, 45443, and 45451)

In relation to items 45440, 45443 and 45451, each site where there is an excision of a lesion and a skin graft (or a skin graft without an excision at the same sitting), is considered a separate procedure. The site of each procedure should be clearly documented in the patient records.

Item 45451 is not to be used for small punch grafts. Defects with an average diameter of less than 5 mm can generally be closed by direct suturing.

TN.8.267 Bony Reshaping - (Item 45609)

Item 45609 applies when in conjunction with a bone-containing free flap (i.e. in association with items 46060 to 46068).

TN.8.268 Dissection of Perforator Flaps - (Items 46050 and 46052)

Item 46050 represents a complete stand-alone procedure.
Item 46052 should be performed alongside a microsurgical procedure.

TN.8.269 Advancement, Retrusion or Alteration of Tilt by Osteotomy in Standard Planes - (Items 46150, 46151, 46152 and 46153)

Examples of mandible and maxilla (bimaxillary) procedures for advancement, retrusion or alteration of tilt by osteotomies in standard planes include sagittal split of mandible and horizontal osteotomy of maxilla.

TN.8.270 Procedures for Thoracic Outlet Syndrome - (Items 46170 - 46185)

Items 46174 and 46175 may be used as a standalone item or in conjunction with items 46177 to 46185.

Item 46176 may be used as a standalone item or in conjunction with items 46170 to 46173.

For items 46177, 46178 and 46179, an example of "single cord or trunk" is the upper trunk. These items should not be used for reconstruction of peripheral nerves.

For items 46177 to 46185, examples of appropriate methods of reconstruction include nerve grafts, vascularised nerve conduit and nerve transfers.

TN.8.271 Direct and Indirect Flap - (Item 45209 and 45212)

Item 45209, for the first stage of multistage flap repair procedure, should be performed in hospital.

Item 45212, for the second or third stage of multistage flap repair procedure, would generally be performed under sedation or general anaesthetic in hospital, with the exceptional of flap division, which can be performed under local anaesthetic out of hospital.

TN.8.272 Procedures that should be performed in-hospital - (Items 31344, 31386, 31387, 31388, 45027, 45209, 45562, 45563, 45614, 45671, 45855, 45857, 46092, 46094)

The above items should be performed in-hospital.

TN.8.273 Modifier Item for Burns Involving Hands, Face or Anterior Neck - (Item 46100)

Item 46100 is a modifier item that provides extra funding for burns involving the hands, face and anterior neck.

The modifier item can be co-claimed with any of items 46101 to 46135 (other than item 46112 or 46124), where excision of burnt tissue or definitive burn wound closure involves greater than 1% of the hands, face or anterior neck.

The modifier items cannot be co-claimed with whole-of-face burns items 46112, 46124 or 46136.

The derived fee for claims including the modifier item will be an additional 40% of the fee for the co-claimed service.

TN.8.274 Rules for Burns Excision and Closure Items - (Items 46100 to 46136)

Only one item can be claimed from the excision of burnt tissue items (items 46101 to 46111) for one provider in one operation.

Item 46112, for excision of burnt tissue involving whole of face, may be claimed with one excision of burnt tissue item (items 46101 to 46111), based on the percentage of total body surface (excluding the face).

For any size of burn, each surgeon can work with another surgeon and each surgeon chooses the excision item from items 46101 to 46112 based on the area that they, as an individual surgeon, have excised.

Where two surgeons are claiming item numbers, the sum of items of each of the surgeons should match the total percentage surface area of burn excised for that patient.

Excision of burnt tissue items (items 46101 to 46112) can be co-claimed with immediate closure items (items 46113 to 46124), but not with delayed definitive closure items (items 46130 to 46136).

When immediate closure is being performed, if it is indicated, both an immediate closure item (items 46113 to 46124) and a non-excisional debridement item (items 46125 to 46129) can be claimed.

Delayed definitive closure items (items 46130 to 46136) cannot be co-claimed with excision of burnt tissue items (items 46101 to 46112), immediate closure items (items 46113 to 46124) or non-excisional debridement items (items 46125 to 46129).

The modifier item (46100) can be co-claimed with the excision of burnt tissue items, immediate closure items, the non-excisional debridement items and the delayed closure items, but it cannot to co-claimed with whole-of-face items 46112, 46124 or 46136.

TN.8.275 Aftercare - (item 46108)

Item 46108 excludes aftercare and therefore professional attendances necessary for the purposes of post-operative treatment of the patient can be claimed.

TN.8.276 Abdominoplasty for abdominal wall defects - (Items 30175)

In the context of eligibility for item 30175, acceptable examples of conservative non-surgical treatment must include physiotherapy, however could also include symptomatic management with pain medication, lower back braces, lifestyle changes and/or exercise.

MBS benefits are not available for surgery performed for cosmetic purposes.

Diagnostic imaging refers to imaging provided by a radiology provider. Diagnostic imaging reports, symptoms of pain and discomfort, and failure to respond to non-surgical conservative treatment must be documented in patient notes.

TN.8.277 Contraindications for an artificial bowel sphincter (item 32221)

An artificial bowel sphincter under item 32221 is contraindicated in:

(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and

(b) patients who have had an adverse reaction to radiopaque solution; and

(c) patients who engage in receptive anal intercourse.

TN.8.278 Balloon valvuloplasty co-claiming restriction with Transcatheter Aortic Valve Implantation (TAVI) items

The services performed under TAVI items (38495, 38514 and 38522) are complete medical services and include balloon valvuloplasty as part of the TAVI procedural service. MBS item 38270 for balloon valvuloplasty should not be co-claimed with TAVI items for the same occasion of service.

Accompanying text is required for claims where a TAVI item and item 38270 are performed on the same day at separate occasions. Suitable texts could include 'separate attendances" or "10 AM and 3PM

Providers are legally responsible for services billed under their provider number or their own name. This includes any incorrect billing of services that result in overpayment of Medicare benefits, regardless of who does the billing or receives the benefit.

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 (i.e. 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 (i.e. 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 Services Australia website.

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

Under the RVG, the 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

As per clause 5.9.5 of Schedule 1 of the GMST, all RVG items 23010 to 24136 apply to a service provided to a patient under anaesthesia, but only if the anaesthesia start and end times are recorded in writing.

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 (item 25013) or at least 75 years (item 25014).
- For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).
- For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).
- For a perfusion service in association with *after hours emergency surgery (item 25050).

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

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

Definition of Emergency

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

Definition of After Hours

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

TN.10.4 Deriving the Schedule Fee under the RVG

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

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x $20.10)
20840	Anaesthesia for resection of perforated bowel	6	$120.60
23200	Time - 4 hours 40 minutes	24	$482.40
25000	Modifier - Physical sttaus	1	$20.10
22012	Central Venous Pressure Monitoring	3	$60.30
	TOTAL	**34**	**$683.40**

After Hours Emergency Services

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

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x $20.10)

20840	Anaesthesia for resection of perforated bowel	6	$120.60
23200	Time - 4 hours 40 minutes	24	$482.40
25000	Modifier - Physical status	1	$20.10
22012	Central Venous Pressure Monitoring	3	$60.30
	TOTAL	**34**	**Schedule fee = $683.40**
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
25014	Physical Status - 75 or over	1	$20.10
	TOTAL	**20**	**$402.00**

Prolonged Anaesthesia

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

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

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

Staffing

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

Facilities

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

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

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

TN.10.6 Account Requirements

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

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

TN.10.7 General Information

The *Health Insurance Act 1973* 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 TN.10.8).

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 TN.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 pain or during labour, the service falls under Group T7.

If not stipulated in the item descriptor, 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.

If stipulated in the item descriptor, 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 the block will not attract benefit under the relevant item in Group T7 unless the block has been performed using a targeted percutaneous approach. If the block has been performed using a targeted percutaneous approach this must be noted on the Medicare claim.

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 after 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 other than in association with anaesthesia.

Items 22012 and 22014

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

Items 22012, 22014 and 22025

A patient who is categorised as having a high risk of complications is one where clinical indications allow for the following items to be claimed (in conjunction with items 22012, 22014 and 22025) with item 25000, item 25005 or item 25010 modifiers, and/or item 25013, and/or item 25014, and/or items 25020, 25025 and/or when the basic surgical item value is 10 or more units, and/or is conjunction with items in group T10 Subgroup 13 (Shoulder and Axilla), or with items 23170 – 24136 (for procedures of greater than four hours duration) noting this is not an exhaustive list.

Item 22042

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

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

TN.10.9 Assistance in the Administration of Anaesthesia

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

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

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

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

Assistance in the administration of elective anaesthesia (Item 25205)

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

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

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

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

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

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

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

22060	**WHOLE BODY PERFUSION, CARDIAC BYPASS**, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) *(See para TN.10.10 of explanatory notes to this Category)*

(b) plus, the time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136), for example:

23170	4:01 HOURS TO 4:10 HOURS (21 basic units)

plus, where appropriate

(c) modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 - 25020), for example:

25014	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more (1 basic unit)

The time component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

Item 22065 may only be used in association with item 22060.

Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10.

The medical practitioner providing the service must comply with the training requirements in the Australian and New Zealand College of Anaesthetists *Guidelines for Major Extracorporeal Perfusion* (PS27).

Benefits are not payable if another person primarily and/or continuously operates the Heart Lung Machine.

TN.10.12 Discontinued Procedure - (Item 21990)

Item 21990 applies when a patient has been anaesthetised but the proposed procedure has been abandoned prior to surgery commencing.

Claims should include notation of the surgery or procedure which had been proposed.

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

TN.10.13 Anaesthesia in Connection with a Procedure not Identified as Attracting a Medicare Benefit for Anaesthesia - (Item 21997)

Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary.

TN.10.14 Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905)

Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e. removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

TN.10.15 Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172)

Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

TN.10.16 Anaesthesia in Connection with an Oral and Maxillofacial Service - (Category 4 of the Medicare Benefits Schedule)

Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG. Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

TN.10.17 Nerve or Plexus Blocks for Post Operative Pain - (Items 22031 to 22041)

Items 22031 to 22041

Benefits are only payable for intra-operative nerve or plexus blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22041.

Items 22031 and 22036

For items 22031 and 22036, postoperative pain management means that the injected therapeutic substance is expected to prolong the analgesic effect of the epidural or intrathecal technique.

Item 22031 (initial intrathecal or epidural injection)

Benefits are payable under item 22031 for the initial intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, for the control of post-operative pain. Benefit is not payable for subsequent intra-operative intrathecal and epidural injection (item 22036) in the same anaesthetic episode. Where subsequent infusion is provided post operatively, to maintain analgesia, benefit would be payable under items 18222 or 18225.

Item 22036 (subsequent intrathecal or epidural injection)

Benefits are payable under item 22036 for subsequent intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, performed intra-operatively, for postoperative pain management, where the catheter is already in-situ. Benefits are not payable under this item where the initial injection was performed intra-operatively, under item 22031, in the same anaesthetic episode.

Item 22041 (plexus or nerve block)

Benefits are payable under item 22041 in addition to the general anaesthesia for the related procedure.

TN.10.18 Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192)

The term 'extensive' in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteectomies 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.10.27 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.

Services Australia (SA) has developed a Health Practitioner Guideline to substantiate that a patient had a pre-existing condition at the time of the service which is located on the SA 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 Services Australia notified of that recognition.

TR.8.2 Selective Coronary Angiography Indications

Clause 5.10.17A Items 38244, 38247, 38307, 38308, 38310, 38316, 38317 and 38319—patient eligibility and timing

(1) A patient is eligible for a service to which item 38244, 38247, 38307, 38308, 38310, 38316, 38317 or 38319 applies if:

(a) subclause (2) applies to the patient; and

(b) a service to which the item applies has not been provided to the patient in the previous 3 months, unless:

(i) the patient experiences a new acute coronary syndrome or angina, as described in paragraph (2)(a), (b) or (c), in that period; or

(ii) for a service to which item 38316, 38317 or 38319 applies—the service was provided to the patient in that period as a subsequent stage following an initial primary percutaneous coronary intervention procedure.

(2) This subclause applies to a patient who has:

(a) an acute coronary syndrome evidenced by any of the following:

(i) ST segment elevation;

(ii) new left bundle branch block;

(iii) troponin elevation above the local upper reference limit;

(iv) new resting wall motion abnormality or perfusion defect;

(v) cardiogenic shock;

(vi) resuscitated cardiac arrest;

(vii) ventricular fibrillation;

(viii) sustained ventricular tachycardia; or

(b) unstable angina or angina equivalent with a crescendo pattern, rest pain or other high-risk clinical features, such as hypotension, dizziness, pallor, diaphoresis or syncope occurring at a low threshold; or

(c) either of the following, detected on computed tomography coronary angiography:

(i) significant left main coronary artery disease with greater than 50% stenosis or a cross-sectional area of less than 6 mm2;

(ii) severe proximal left anterior descending coronary artery disease (with stenosis of more than 70% or a cross-sectional area of less than 4 mm2 before the first major diagonal branch).

TR.8.3 Acute Coronary Syndrome - Selective Coronary Angiography and Percutaneous Coronary Intervention Indications

Clause 5.10.17B Items 38248 and 38249—patient eligibility

(1) A patient is eligible for a service to which item 38248 or 38249 applies if:

(a) subclause (2) applies to the patient; or

(b) the patient is recommended for coronary angiography as a result of a heart team conference that meets the requirements of subclause (3).

(2) This subclause applies to a patient who has:

(a) limiting angina or angina equivalent, despite an adequate trial of optimal medical therapy; or

(b) high risk features, including at least one of the following:

(i) myocardial ischaemia demonstrated on functional imaging;

(ii) ST segment elevation, sustained ST depression, hypotension or a Duke treadmill score of minus 11 or less, demonstrated by stress electrocardiogram testing;

(iii) computed tomography coronary angiography evidence of one or more coronary arteries with stenosis of 70% or more; or

(iv) left ventricular dysfunction with an ejection fraction of less than 40% or segmental wall motion abnormality at rest

(3) For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:

(a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:

(i) an interventional cardiologist;

(ii) a non-interventional cardiologist;

(iii) a specialist or consultant physician; and

(b) the team must:

(i) assess the patient's risk and technical suitability to receive the service; and

(ii) make a recommendation about whether or not the patient is suitable for invasive coronary angiography; and

(c) a record of the conference must be created, and must include the following:

(i) the particulars of the assessment of the patient during the conference;

(ii) the recommendations made as a result of the conference;

(iii) the names of the members of the team making the recommendations.

TR.8.4 Stable - Percutaneous Coronary Intervention Indications

Clause 5.10.17C Items 38311, 38313, 38314, 38320, 38322 and 38323—patient eligibility

(1) A patient is eligible for a service to which item 38311, 38313, 38314, 38320, 38322 or 38323 applies if:

(a) subclause (2) applies to the patient; or

(b) the patient is recommended for the service as a result of a heart team conference that meets the requirements of subclause (4).

(2) This subclause applies to a patient if:

(a) the patient has any of the following:

(i) limiting angina or angina equivalent despite an adequate trial of optimal medical therapy;

(ii) myocardial ischaemia demonstrated on functional imaging;

(iii) high risk features such as ST segment elevation, sustained ST depression, hypotension or a Duke treadmill score of minus 11 or less, demonstrated by stress electrocardiogram testing; and

(b) the patient has either of the following in a vascular territory treated:

(i) a stenosis of 70% or more;

(ii) a fractional flow reserve of 0.80 or less, or non-hyperaemic pressure ratios distal to the lesions of 0.89 or less; and

(c) for items 38314 and 38323—either:

(i) the patient does not have diabetes mellitus and the multi-vessel coronary artery disease of the patient meets the criterion in subclause (3); or

(ii) despite a recommendation that surgery is preferable, the patient has expressed a preference for catheter-based intervention.

(3) For the purposes of subparagraph (2)(c)(i), the criterion for the multi-vessel coronary artery disease is that the disease does not involve any of the following:

(a) stenosis of more than 50% in the left main coronary artery;

(b) bifurcation lesions involving side branches with a diameter of more than 2.75 mm;

(c) chronic vessel occlusions for more than 3 months;

(d) severely angulated or calcified lesions;

(e) a SYNTAX score of more than 23.

(4) For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:

(a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:

(i) an interventional cardiologist;

(ii) a specialist or consultant physician;

(iii) for items 38314 and 38323—a cardiothoracic surgeon;

(iv) for items 38311, 38313, 38320 and 38322—a cardiothoracic surgeon or a non-interventional cardiologist; and

(b) the team must:

(i) assess the patient's risk and technical suitability to receive the service; and

(ii) make a recommendation about whether or not the patient is suitable for percutaneous coronary intervention; and

(c) a record of the conference must be created, and must include the following:

(i) the particulars of the assessment of the patient during the conference;

(ii) the recommendations made as a result of the conference;

(iii) the names of the members of the team making the recommendations.

TR.8.5 Selective Coronary Angiography and Percutaneous Coronary Intervention - Documentation Requirements

Clause 5.10.17D Restriction on items 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38320, 38322, 38323, 38316, 38317 and 38319—reports and clinical notes

Items 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38320, 38322, 38323, 38316, 38317 and 38319 apply to a service provided to a patient only if a report or clinical note:

(a) is prepared for the service; and

(b) includes documentation that demonstrates how the item applies to the service, including how the patient is eligible for the service.

TR.8.6 Heart Team Conferences - Items 38248, 38249, 38311, 38313, 38320, 38322 and 57364

Definition of a heart team conference: relevant to items 38248, 38249, 38311, 38313, 38320, 38322 and 57364

(a) A heart team conference is a team of 3 or more participants who are cardiac specialists; where:

i. the first participant is a specialist or consultant physician who is an interventional cardiologist; and
ii. the second participant is a specialist or consultant who is a non-interventional cardiologist; and
iii. the third participant is a specialist or consultant physician; and

(b) the team assesses a patient's risk and technical suitability to receive the service; and

(c) the result of the heart team conference's assessment is that the team makes a recommendation about whether or not the patient is suitable for selective coronary angiography (for items 38248, 38249, 38320) or percutaneous coronary intervention (for items 38311, 38313, 38320, 38322) ; and

(d) the particulars of the assessment and recommendation/s, and the names of those providers making the recommendation/s are recorded in writing.

Note: For non-complex stable triple vessel disease, providers are encouraged to include a cardiothoracic surgeon in the heart team.

TR.8.7 Heart Team Conferences for items 38314 and 38323

Definition of a heart team conference: relevant to items 38314 and 38323

(a) A heart team conference is a team of 3 or more participants who are cardiac specialists, where:

i. the first participant is a specialist or consultant physician who is an interventional cardiologist; and
ii. the second participant is a specialist or consultant who is a cardiothoracic surgeon; and
iii. the third participant is a specialist or consultant who is a non-interventional cardiologist ; and

(b) the team assesses a patient's risk and technical suitability to receive the service; and

(c) the result of the heart team conference's assessment is that the team makes a recommendation about whether or not the patient is suitable for percutaneous coronary intervention; and

(d) the particulars of the assessment and recommendation/s, and the names of those providers making the recommendation/s are recorded in writing.

THERAPEUTIC PROCEDURES ITEMS

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	**1. HYPERBARIC OXYGEN THERAPY**
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 1. Hyperbaric Oxygen Therapy
Fee 13015	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. (See para TN.1.1 of explanatory notes to this Category) **Fee:** $279.05 **Benefit:** 75% = $209.30 85% = $237.20
Fee 13020	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance (See para TN.1.1 of explanatory notes to this Category) **Fee:** $283.50 **Benefit:** 75% = $212.65 85% = $241.00
Fee 13025	HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour) (See para TN.1.1 of explanatory notes to this Category) **Fee:** $126.70 **Benefit:** 75% = $95.05 85% = $107.70
Fee 13030	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of an hour) (See para TN.1.1 of explanatory notes to this Category) **Fee:** $178.95 **Benefit:** 75% = $134.25 85% = $152.15

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	**2. DIALYSIS**
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 2. Dialysis
Fee 13100	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day (See para TN.1.2 of explanatory notes to this Category) **Fee:** $149.70 **Benefit:** 75% = $112.30 85% = $127.25

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	2. DIALYSIS
Fee 13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day (See para TN.1.2 of explanatory notes to this Category) **Fee:** $78.00 **Benefit:** 75% = $58.50 85% = $66.30
Fee 13104	Planning and management of home dialysis (either haemodialysis or peritoneal dialysis), by a consultant physician in the practice of his or her specialty of renal medicine, for a patient with end-stage renal disease, and supervision of that patient on self-administered dialysis, to a maximum of 12 claims per year (See para TN.1.3, TN.1.23 of explanatory notes to this Category) **Fee:** $162.00 **Benefit:** 85% = $137.70
Fee 13105	Haemodialysis for a patient with end-stage renal disease if: (a) the service is provided by a registered nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner; and (b) the service is supervised by the medical practitioner (either in person or remotely); and (c) the patient's care is managed by a nephrologist; and (d) the patient is treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely); and (e) the patient is not an admitted patient of a hospital; and (f) the service is provided in a Modified Monash 7 area **Fee:** $648.35 **Benefit:** 100% = $648.35
Fee 13106	DECLOTTING OF AN ARTERIOVENOUS SHUNT **Fee:** $132.90 **Benefit:** 75% = $99.70 85% = $113.00
Fee 13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.) **Fee:** $249.40 **Benefit:** 75% = $187.05 85% = $212.00
Fee 13110	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS , removal of (including catheter cuffs) (Anaes.) **Fee:** $250.25 **Benefit:** 75% = $187.70 85% = $212.75

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	3. ASSISTED REPRODUCTIVE SERVICES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 3. Assisted Reproductive Services
Fee 13200	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all

	treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203, 13218 applies - being services rendered during 1 treatment cycle - INITIAL cycle in a single calendar year (See para TN.1.4 of explanatory notes to this Category) **Fee:** $3,406.95 **Benefit:** 75% = $2555.25 85% = $3313.75 **Extended Medicare Safety Net Cap:** $1,894.50
Fee 13201	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13218 applies - being services rendered during 1 treatment cycle - each cycle SUBSEQUENT to the first in a single calendar year (See para TN.1.4 of explanatory notes to this Category) **Fee:** $3,186.85 **Benefit:** 75% = $2390.15 85% = $3093.65 **Extended Medicare Safety Net Cap:** $2,750.00
Fee 13202	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE THAT IS CANCELLED BEFORE OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, semen preparation, ultrasound examinations, but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which Item 13200, 13201, 13203, 13218, applies being services rendered during 1 treatment cycle (See para TN.1.4 of explanatory notes to this Category) **Fee:** $509.85 **Benefit:** 75% = $382.40 85% = $433.40 **Extended Medicare Safety Net Cap:** $73.40
Fee 13203	Ovulation monitoring services for artificial insemination or gonadotrophin, stimulated ovulation induction, including quantitative estimation of hormones and ultrasound examinations, being services rendered during one treatment cycle but excluding a service to which item 13200, 13201, 13202, 13212, 13215 or 13218 applies (See para TN.1.4 of explanatory notes to this Category) **Fee:** $533.05 **Benefit:** 75% = $399.80 85% = $453.10 **Extended Medicare Safety Net Cap:** $122.20
Fee 13207	Biopsy of an embryo, from a patient who is eligible for a service described in item 73384 under clause 2.7.3A of the pathology services table (see PR.7.1), for the purpose of providing a sample for pre-implantation genetic testing—applicable to one or more tests performed in one assisted reproductive treatment cycle (See para PR.7.1 of explanatory notes to this Category) **Fee:** $121.05 **Benefit:** 75% = $90.80 85% = $102.90
Fee 13209	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle (See para TN.1.4 of explanatory notes to this Category) **Fee:** $92.75 **Benefit:** 75% = $69.60 85% = $78.85 **Extended Medicare Safety Net Cap:** $12.30

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	3. ASSISTED REPRODUCTIVE SERVICES
Fee 13212	Oocyte retrieval for the purpose of assisted reproductive technologies-only if rendered in connection with a service to which item 13200 or 13201 applies (Anaes.) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $388.20 **Benefit:** 75% = $291.15 85% = $330.00 **Extended Medicare Safety Net Cap:** $79.50
Fee 13215	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 or 13218 applies, being services rendered in one treatment cycle (Anaes.) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $121.75 **Benefit:** 75% = $91.35 85% = $103.50 **Extended Medicare Safety Net Cap:** $55.00
Fee 13218	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, 13212 applies (Anaes.) (See para TN.1.4, TN.1.5 of explanatory notes to this Category) **Fee:** $869.10 **Benefit:** 75% = $651.85 85% = $775.90 **Extended Medicare Safety Net Cap:** $794.50
Fee 13221	Preparation of semen for the purpose of artificial insemination-only if rendered in connection with a service to which item 13203 applies (See para TN.1.4 of explanatory notes to this Category) **Fee:** $55.60 **Benefit:** 75% = $41.70 85% = $47.30 **Extended Medicare Safety Net Cap:** $24.50
Fee 13241	Open surgical testicular sperm retrieval, unilateral, using operating microscope, including the exploration of scrotal contents, with biopsy, for the purposes of intracytoplasmic sperm injection, for male factor infertility, not being a service associated with a service to which item 13218 or 37604 applies (H) (Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $930.95 **Benefit:** 75% = $698.25
Fee 13251	INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which Item 13203 or 13218 applies (See para TN.1.5 of explanatory notes to this Category) **Fee:** $457.75 **Benefit:** 75% = $343.35 85% = $389.10 **Extended Medicare Safety Net Cap:** $122.20
Fee 13260	Processing and cryopreservation of semen for fertility preservation treatment before or after completion of gonadotoxic treatment for malignant or non-malignant conditions, in a post-pubertal male in Tanner stages II-V, up to 60 years old, if the patient is referred by a specialist or consultant physician, initial cryopreservation of semen (not including storage) - one of a maximum of two semen collection cycles per patient in a lifetime. (See para TN.1.22 of explanatory notes to this Category) **Fee:** $454.50 **Benefit:** 75% = $340.90 85% = $386.35 **Extended Medicare Safety Net Cap:** $295.45

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	3. ASSISTED REPRODUCTIVE SERVICES
Fee 13290	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required **Fee:** $223.65 **Benefit:** 75% = $167.75 85% = $190.15

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	4. PAEDIATRIC & NEONATAL
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 4. Paediatric & Neonatal
Fee 13300	UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate **Fee:** $62.35 **Benefit:** 75% = $46.80 85% = $53.00
Fee 13303	UMBILICAL ARTERY CATHETERISATION with or without infusion **Fee:** $92.45 **Benefit:** 75% = $69.35 85% = $78.60
Fee 13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor **Fee:** $365.90 **Benefit:** 75% = $274.45 85% = $311.05
Fee 13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected **Fee:** $312.00 **Benefit:** 75% = $234.00 85% = $265.20
Fee 13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS **Fee:** $31.15 **Benefit:** 75% = $23.40 85% = $26.50
Fee 13318	CENTRAL VEIN CATHETERISATION - by open exposure in a patient under 12 years of age (Anaes.) (See para TN.1.6 of explanatory notes to this Category) **Fee:** $249.10 **Benefit:** 75% = $186.85 85% = $211.75
Fee 13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes.) **Fee:** $249.10 **Benefit:** 75% = $186.85 85% = $211.75

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	5. CARDIOVASCULAR
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 5. Cardiovascular
Fee 13400	Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (H) (Anaes.)

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	5. CARDIOVASCULAR
	Fee: $106.05 **Benefit:** 75% = $79.55

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	6. GASTROENTEROLOGY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 6. Gastroenterology
Fee 13506	GASTRO-OESOPHAGEAL balloon intubation, for control of bleeding from gastric oesophageal varices **Fee:** $202.00 **Benefit:** 75% = $151.50 85% = $171.70

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	8. HAEMATOLOGY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 8. Haematology
Fee 13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.) **Fee:** $365.05 **Benefit:** 75% = $273.80 85% = $310.30
Fee 13703	Transfusion of blood, including collection from donor, when used for intra-operative normovolaemic haemodilution **Fee:** $130.85 **Benefit:** 75% = $98.15 85% = $111.25
Fee 13706	TRANSFUSION OF BLOOD or bone marrow already collected (See para TN.1.7 of explanatory notes to this Category) **Fee:** $91.25 **Benefit:** 75% = $68.45 85% = $77.60
Fee 13750	THERAPEUTIC HAEMAPHERESIS for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies - payable once per day **Fee:** $149.70 **Benefit:** 75% = $112.30 85% = $127.25
Fee 13755	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day **Fee:** $149.70 **Benefit:** 75% = $112.30 85% = $127.25
Fee 13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda

	Fee: $79.90 **Benefit:** 75% = $59.95 85% = $67.95
Fee 13760	In vitro processing with cryopreservation of bone marrow or peripheral blood, for autologous stem cell transplantation for a patient receiving high-dose chemotherapy for management of: (a) aggressive malignancy; or (b) malignancy that has proven refractory to prior treatment (See para TN.1.26 of explanatory notes to this Category) **Fee:** $835.20 **Benefit:** 75% = $626.40 85% = $742.00
Amend Fee 13761 S	Extracorporeal photopheresis for the treatment of chronic graft-versus-host disease, if: (a) the person is: (i) has received allogeneic haematopoietic stem cell transplantation; and (ii) has been diagnosed with chronic graft versus host disease following the transplantation; and (iii) steroid treatment is clinically unsuitable as the disease is steroid refractory or the person is steroid-dependent or steroid-intolerant; and (b) the person has not previously received extracorporeal photopheresis treatment; and (c) the service is delivered using an integrated, closed extracorporeal photopheresis system; and (d) the service is provided in combination with the use of methoxsalen that is listed on the Pharmaceutical Benefits Scheme; and (e) the service is provided by, or on behalf of, a specialist or consultant physician who: (i) is practising in the speciality of haematology or oncology; and (ii) has experience with allogeneic bone marrow transplantation. Applicable once per treatment session (See para TN.1.29 of explanatory notes to this Category) **Fee:** $2,008.70 **Benefit:** 75% = $1506.55 85% = $1915.50
Amend Fee 13762 S	Extracorporeal photopheresis for the treatment of chronic graft-versus-host disease, if: (a) the person is: (i) has received allogeneic haematopoietic stem cell transplantation; and (ii) has been diagnosed with chronic graft versus host disease following the transplantation; and (iii) steroid treatment is clinically unsuitable as the disease is steroid refractory or the person is steroid-dependent or steroid-intolerant; and

	(b) the person has previously received an extracorporeal photopheresis treatment cycle and had a partial or complete response in at least one organ in response to treatment; and (c) the person requires further extracorporeal photopheresis; and (d) the service is delivered using an integrated, closed extracorporeal photopheresis system; and (e) the service is provided in combination with the use of methoxsalen that is listed on the Pharmaceutical Benefits Scheme; and (f) the service is provided by, or on behalf of, a specialist or consultant physician who: (i) is practising in the speciality of haematology or oncology; and (ii) has experience with allogeneic bone marrow transplantation. Applicable once per treatment session (See para TN.1.29 of explanatory notes to this Category) **Fee:** $2,008.70 **Benefit:** 75% = $1506.55 85% = $1915.50

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support
Fee 13815	Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by percutaneous or open exposure other than a service to which item 13318 applies (Anaes.) No separate ultrasound item is payable with this item. (Anaes.) (See para TN.1.6, TN.1.10 of explanatory notes to this Category) **Fee:** $124.50 **Benefit:** 75% = $93.40 85% = $105.85
Fee 13818	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.) (See para TN.1.10 of explanatory notes to this Category) **Fee:** $124.55 **Benefit:** 75% = $93.45 85% = $105.90
Fee 13830	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day **Fee:** $82.50 **Benefit:** 75% = $61.90 85% = $70.15
Fee 13832	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-arterial cardiopulmonary extracorporeal life support No separate ultrasound item is payable with this item (See para TN.1.10 of explanatory notes to this Category) **Fee:** $965.75 **Benefit:** 75% = $724.35 85% = $872.55

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
Fee 13834	Veno–arterial cardiopulmonary extracorporeal life support, management of—the first day (See para TN.1.10 of explanatory notes to this Category) **Fee:** $540.65 **Benefit:** 75% = $405.50 85% = $459.60
Fee 13835	Veno–arterial cardiopulmonary extracorporeal life support, management of—each day after the first (See para TN.1.10 of explanatory notes to this Category) **Fee:** $125.75 **Benefit:** 75% = $94.35 85% = $106.90
Fee 13837	Veno-venous pulmonary extracorporeal life support, management of—the first day (See para TN.1.10 of explanatory notes to this Category) **Fee:** $540.65 **Benefit:** 75% = $405.50 85% = $459.60
Fee 13838	Veno-venous pulmonary extracorporeal life support, management of—each day after the first (See para TN.1.10 of explanatory notes to this Category) **Fee:** $125.75 **Benefit:** 75% = $94.35 85% = $106.90
Fee 13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes **Fee:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
Fee 13840	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-venous pulmonary extracorporeal life support No separate ultrasound item is payable with this item (See para TN.1.10 of explanatory notes to this Category) **Fee:** $647.05 **Benefit:** 75% = $485.30 85% = $553.85
Fee 13842	Intra-arterial cannulation, including under ultrasound guidance where clinically appropriate, for the purpose of intra-arterial pressure monitoring or arterial blood sampling (or both) No separate ultrasound item is payable with this item (See para TN.1.10 of explanatory notes to this Category) **Fee:** $102.45 **Benefit:** 75% = $76.85 85% = $87.10
Fee 13848	Counterpulsation by intra-aortic balloon-management including associated consultations and monitoring of parameters by means of full haemodynamic assessment and management on several occasions on a day – each day (See para TN.1.10 of explanatory notes to this Category) **Fee:** $171.00 **Benefit:** 75% = $128.25 85% = $145.35
Fee 13851	Ventricular assist device, management of, for a patient admitted to an intensive care unit for implantation of the device or for complications arising from implantation or management of the device - first day (See para TN.1.10 of explanatory notes to this Category) **Fee:** $540.65 **Benefit:** 75% = $405.50 85% = $459.60
Fee 13854	Ventricular assist device, management of, for a patient admitted to an intensive care unit, including management of complications arising from implantation or management of the device - each day after the first day (See para TN.1.10 of explanatory notes to this Category) **Fee:** $125.75 **Benefit:** 75% = $94.35 85% = $106.90

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION (other than in the context of an anaesthetic for surgery), outside an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit
Fee 13857	(See para TN.1.10 of explanatory notes to this Category) **Fee:** $160.35 **Benefit:** 75% = $120.30 85% = $136.30

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 10. Management And Procedures Undertaken In An Intensive Care Unit
	(Note: See para T1.8 of Explanatory Notes to this Category for definition of an Intensive Care Unit)
Fee 13870	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on the first day (H) (See para TN.1.9, TN.1.11, TN.1.10 of explanatory notes to this Category) **Fee:** $396.60 **Benefit:** 75% = $297.45
Fee 13873	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on each day subsequent to the first day (H) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $294.15 **Benefit:** 75% = $220.65
Fee 13876	CENTRAL VENOUS PRESSURE, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter in an intensive care unit and managed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - once only for each type of pressure on any calendar day (up to a maximum of 4 pressures) (H) (See para TN.1.9, TN.1.11, TN.1.10 of explanatory notes to this Category) **Fee:** $84.25 **Benefit:** 75% = $63.20
Fee 13881	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION, in an Intensive Care Unit, not in association with any anaesthetic service, by a specialist or consultant physician for the purpose of subsequent ventilatory support (H) (See para TN.1.9 of explanatory notes to this Category) **Fee:** $160.35 **Benefit:** 75% = $120.30

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
Fee 13882	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by invasive means, or by non-invasive means where the only alternative to non-invasive ventilatory support would be invasive ventilatory support, by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care, each day (H) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $126.20 **Benefit:** 75% = $94.65
Fee 13885	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on the first day (H) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $168.30 **Benefit:** 75% = $126.25
Fee 13888	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on each day subsequent to the first day (H) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $84.25 **Benefit:** 75% = $63.20
Fee 13899	Preparation of Goals of Care is provided outside of an intensive care unit. Refer to explanatory note TN.1.11 for further information about Goals of Care attendance Professional attendance, outside an intensive care unit, for at least 60 minutes spent in preparation of goals of care for a gravely ill patient lacking current goals of care, by a specialist in the specialty of intensive care who takes overall responsibility for the preparation of the goals of care for the patient Item 13899 cannot be co-claimed with item 13870 or item 13873 on the same day (See para TN.1.11 of explanatory notes to this Category) **Fee:** $293.40 **Benefit:** 75% = $220.05 85% = $249.40 **Extended Medicare Safety Net Cap:** $500.00

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	11. CHEMOTHERAPEUTIC PROCEDURES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 11. Chemotherapeutic Procedures
Fee 13950 S	Parenteral administration of one or more antineoplastic agents, including agents used in cytotoxic chemotherapy or monoclonal antibody therapy but not agents used in anti-resorptive bone therapy or hormonal therapy, by or on behalf of a specialist or consultant physician—attendance for one or more episodes of administration Note: The fee for item 13950 contains a component which covers the accessing of a long-term drug delivery device. TN.1.27 refers (See para TN.1.12, TN.1.27 of explanatory notes to this Category) **Fee:** $118.30 **Benefit:** 75% = $88.75 85% = $100.60

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 12. Dermatology
Fee 14050	UVA or UVB phototherapy administered in a whole body cabinet or hand and foot cabinet including associated consultations other than the initial consultation, if treatment is initiated and supervised by a specialist in the specialty of dermatology Applicable not more than 150 times in a 12 month period (See para TN.1.14 of explanatory notes to this Category) **Fee:** $57.80 **Benefit:** 75% = $43.35 85% = $49.15
Fee 14100	Laser photocoagulation using laser radiation in the treatment of vascular abnormalities of the head or neck, including any associated consultation, if: (a) the abnormality is visible from 3 metres; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes; to a maximum of 4 sessions (including any sessions to which this item or any of items 14106 to 14118 apply) in any 12 month period (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $167.00 **Benefit:** 75% = $125.25 85% = $141.95 **Extended Medicare Safety Net Cap:** $133.60
Fee 14106	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment less than 150 cm^2 (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $175.40 **Benefit:** 75% = $131.55 85% = $149.10
Fee 14115	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment 150 cm^2 to 300 cm^2 (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $280.90 **Benefit:** 75% = $210.70 85% = $238.80
Fee 14118	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period—area of treatment more than 300 cm^2 (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $356.70 **Benefit:** 75% = $267.55 85% = $303.20

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	12. DERMATOLOGY
	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.)
Fee 14124	(See para TN.1.15 of explanatory notes to this Category) **Fee:** $167.00 **Benefit:** 75% = $125.25 85% = $141.95

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	13. OTHER THERAPEUTIC PROCEDURES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 13. Other Therapeutic Procedures
Fee 14201	POLY-L-LACTIC ACID, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 - once per patient (See para TN.1.16 of explanatory notes to this Category) **Fee:** $259.40 **Benefit:** 75% = $194.55 85% = $220.50 **Extended Medicare Safety Net Cap:** $38.95
Fee 14202	POLY-L-LACTIC ACID, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 (See para TN.1.16 of explanatory notes to this Category) **Fee:** $131.30 **Benefit:** 75% = $98.50 85% = $111.65 **Extended Medicare Safety Net Cap:** $19.70
Fee 14203	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) **Fee:** $56.00 **Benefit:** 75% = $42.00 85% = $47.60
Fee 14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula (See para TN.1.4, TN.1.17 of explanatory notes to this Category) **Fee:** $39.00 **Benefit:** 75% = $29.25 85% = $33.15
Fee 14212	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.) **Fee:** $202.90 **Benefit:** 75% = $152.20 85% = $172.50
Fee 14216 S	Professional attendance on a patient by a psychiatrist, who has undertaken training in Repetitive Transcranial Magnetic Stimulation (rTMS), for treatment mapping for rTMS, if the patient: (a) has not previously received any prior transcranial magnetic stimulation therapy in a public or private setting; and

	(b) is at least 18 years old; and (c) is diagnosed with a major depressive episode; and (d) has failed to receive satisfactory improvement for the major depressive episode despite the adequate trialling of at least 2 different classes of antidepressant medications, unless contraindicated, and all of the following apply: (i) the patient's adherence to antidepressant treatment has been formally assessed; (ii) the trialling of each antidepressant medication has been at the recommended therapeutic dose for a minimum of 3 weeks; (iii) where clinically appropriate, the treatment has been titrated to the maximum tolerated therapeutic dose; and (e) has undertaken psychological therapy, if clinically appropriate (See para TN.1.28 of explanatory notes to this Category) **Fee:** $196.20 **Benefit:** 75% = $147.15 85% = $166.80 **Extended Medicare Safety Net Cap:** $552.50
Fee 14217 S	Repetitive Transcranial Magnetic Stimulation (rTMS) treatment of up to 35 services provided by, or on behalf of, a psychiatrist who has undertaken training in rTMS, if the patient has previously received a service under item 14216—each service up to 35 services (See para TN.1.28 of explanatory notes to this Category) **Fee:** $168.40 **Benefit:** 75% = $126.30 85% = $143.15 **Extended Medicare Safety Net Cap:** $349.90
Fee 14218	Implanted infusion pump, refilling of reservoir with a therapeutic agent or agents for infusion to the subarachnoid space or accessing the side port to assess catheter patency, with or without pump reprogramming, for the management of chronic pain, including cancer pain (See para TN.8.244 of explanatory notes to this Category) **Fee:** $107.30 **Benefit:** 75% = $80.50 85% = $91.25
Fee 14219	Professional attendance on a patient by a psychiatrist, who has undertaken training in Repetitive Transcranial Magnetic Stimulation (rTMS), for treatment mapping for rTMS, if the patient: (a) is at least 18 years old; and (b) is diagnosed with a major depressive episode; and (c) has failed to receive satisfactory improvement for the major depressive episode despite the adequate trialling of at least 2 different classes of antidepressant medications, unless contraindicated, and all of the following apply: (i) the patient's adherence to antidepressant treatment has been formally assessed; (ii) the trialling of each antidepressant medication has been at the recommended therapeutic dose for a minimum of 3 weeks;

	(iii) where clinically appropriate, the treatment has been titrated to the maximum tolerated therapeutic dose; and (d) has undertaken psychological therapy, if clinically appropriate; and (e) has previously received an initial service under item 14217 and the patient: (i) has relapsed after a remission following the initial service; and (ii) has had a satisfactory clinical response to the service under item 14217 (which has been assessed by a validated major depressive disorder tool at least 4 months after receiving that service) (See para TN.1.28 of explanatory notes to this Category) **Fee:** $196.20 **Benefit:** 75% = $147.15 85% = $166.80 **Extended Medicare Safety Net Cap:** $552.50
Fee 14220	Repetitive Transcranial Magnetic Stimulation (rTMS) treatment of up to 15 services provided by, or on behalf of, a psychiatrist who has undertaken training in rTMS, if the patient has previously received: (a) a service under item 14217 (which was not provided in the previous 4 months); and (b) a service under item 14219 Each service up to 15 services (See para TN.1.28 of explanatory notes to this Category) **Fee:** $168.40 **Benefit:** 75% = $126.30 85% = $143.15 **Extended Medicare Safety Net Cap:** $349.90
Fee 14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13950 applies **Fee:** $57.50 **Benefit:** 75% = $43.15 85% = $48.90
Fee 14224	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.) **Fee:** $77.05 **Benefit:** 75% = $57.80 85% = $65.50
Fee 14227	IMPLANTED INFUSION PUMP, REFILLING of reservoir, with baclofen, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of severe chronic spasticity (See para TN.1.18 of explanatory notes to this Category) **Fee:** $107.30 **Benefit:** 75% = $80.50 85% = $91.25
Fee 14234	Infusion pump or components of an infusion pump, removal or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (See para TN.1.18 of explanatory notes to this Category) **Fee:** $396.30 **Benefit:** 75% = $297.25
Fee 14237	Infusion pump or components of an infusion pump, subcutaneous implantation of, and intrathecal or epidural spinal catheter insertion, and connection of pump to catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.)

	(See para TN.1.18 of explanatory notes to this Category) **Fee:** $722.75 **Benefit:** 75% = $542.10
Fee 14245	IMMUNOMODULATING AGENT, administration of, by intravenous infusion for at least 2 hours duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme (See para TN.1.19 of explanatory notes to this Category) **Fee:** $107.30 **Benefit:** 75% = $80.50 85% = $91.25
Fee 14247 S	Extracorporeal photopheresis for the treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if a. the service is provided in the initial six months of treatment; and b. the service is delivered using an integrated, closed extracorporeal photopheresis system; and c. the patient is 18 years old or over; and d. the patient has received prior systemic treatment for this condition and experienced either disease progression or unacceptable toxicity while on this treatment; and e. the service is provided in combination with the use of Pharmaceutical Benefits Scheme-subsidised methoxsalen; and f. the service is supervised by a specialist or consultant physician in the speciality of haematology. Applicable once per treatment cycle **Fee:** $2,026.80 **Benefit:** 75% = $1520.10 85% = $1933.60
Fee 14249 S	Extracorporeal photopheresis for the continuing treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if a. in the preceding 6 months: (i) a service to which item 14247 applies has been provided; and (ii) the patient has demonstrated a response to this service; and (iii)the patient requires further treatment; and b. the service is delivered using an integrated, closed extracorporeal photopheresis system; and c. the patient is 18 years old or over; and d. the service is provided in combination with the use of Pharmaceutical Benefits Scheme-subsidised methoxsalen; and e. the service is supervised by a specialist or consultant physician in the speciality of haematology. Applicable once per treatment cycle (See para TN.1.25 of explanatory notes to this Category) **Fee:** $2,026.80 **Benefit:** 75% = $1520.10 85% = $1933.60

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 14. Management and Procedures Undertaken in an Emergency Department
Fee 14255	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $162.50 **Benefit:** 75% = $121.90 85% = $138.15
Fee 14256	Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $312.50 **Benefit:** 75% = $234.40 85% = $265.65
Fee 14257	Resuscitation of a patient provided for at least 2 hours, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $622.35 **Benefit:** 75% = $466.80 85% = $529.15
Fee 14258	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $121.95 **Benefit:** 75% = $91.50 85% = $103.70
Fee 14259	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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $234.40 **Benefit:** 75% = $175.80 85% = $199.25
Fee 14260	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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $466.75 **Benefit:** 75% = $350.10 85% = $396.75
Fee 14263	Minor procedure on a patient by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)

	(See para TN.1.24 of explanatory notes to this Category) **Fee:** $57.20 **Benefit:** 75% = $42.90 85% = $48.65
Fee 14264	Procedure (except a minor procedure) on a patient by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
Fee 14265	Minor procedure on a patient by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $42.90 **Benefit:** 75% = $32.20 85% = $36.50
Fee 14266	Procedure (except a minor procedure) on a patient by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $96.55 **Benefit:** 75% = $72.45 85% = $82.10
Fee 14270	Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a specialist in the practice of the specialist's specialty of emergency medicine in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and (b) occurs at a recognised emergency department of a private hospital (Anaes.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $144.35 **Benefit:** 75% = $108.30 85% = $122.70
Fee 14272	Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (b) occurs at a recognised emergency department of a private hospital (Anaes.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $108.30 **Benefit:** 75% = $81.25 85% = $92.10
Fee 14277	Application of chemical or physical restraint of a patient by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital (See para TN.1.24 of explanatory notes to this Category) **Fee:** $162.50 **Benefit:** 75% = $121.90 85% = $138.15
Fee 14278	Application of chemical or physical restraint of a patient by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital (See para TN.1.24 of explanatory notes to this Category) **Fee:** $121.95 **Benefit:** 75% = $91.50 85% = $103.70

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	14. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN EMERGENCY DEPARTMENT
Fee 14280	Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies (See para TN.1.24 of explanatory notes to this Category) **Fee:** $162.50 **Benefit:** 75% = $121.90 85% = $138.15
Fee 14283	Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies (See para TN.1.24 of explanatory notes to this Category) **Fee:** $121.95 **Benefit:** 75% = $91.50 85% = $103.70
Fee 14285	Emergent intubation, airway management or both of a patient that: (a) is managed by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies (See para TN.1.24 of explanatory notes to this Category) **Fee:** $162.50 **Benefit:** 75% = $121.90 85% = $138.15
Fee 14288	Emergent intubation, airway management or both of a patient that: (a) is managed by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies (See para TN.1.24 of explanatory notes to this Category) **Fee:** $121.95 **Benefit:** 75% = $91.50 85% = $103.70

T2. RADIATION ONCOLOGY	1. SUPERFICIAL
	Group T2. Radiation Oncology
	Subgroup 1. Superficial
Fee 15000	*(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10)* RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given

T2. RADIATION ONCOLOGY	1. SUPERFICIAL
	- 1 field **Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65
Fee 15003	Radiotherapy, superficial (including treatment with x-rays, radium rays or other radioactive substances), not being a service to which another item in this Group applies - each attendance at which fractionated treatment is given - 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15000 plus for each field in excess of 1, an amount of $18.70
Fee 15006	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field **Fee:** $103.35 **Benefit:** 75% = $77.55 85% = $87.85
Fee 15009	Radiotherapy, superficial attendance at which a single dose technique is applied - 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15006 plus for each field in excess of 1, an amount of $20.30
Fee 15012	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80

T2. RADIATION ONCOLOGY	2. ORTHOVOLTAGE
	Group T2. Radiation Oncology
	Subgroup 2. Orthovoltage
Fee 15100	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field (See para TN.2.1 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45
Fee 15103	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 3 or more treatments per week - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) (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 $20.55
Fee 15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field **Fee:** $61.65 **Benefit:** 75% = $46.25 85% = $52.45

T2. RADIATION ONCOLOGY	2. ORTHOVOLTAGE
Fee 15109	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15106 plus for each field in excess of 1, an amount of $24.85
Fee 15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field **Fee:** $131.70 **Benefit:** 75% = $98.80 85% = $111.95
Fee 15115	Radiotherapy, deep or orthovoltage attendance at which a single dose technique is applied - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15112 plus for each field in excess of 1, an amount of $51.80

T2. RADIATION ONCOLOGY	3. MEGAVOLTAGE
	Group T2. Radiation Oncology
	Subgroup 3. Megavoltage
Fee 15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given - 1 field **Fee:** $59.95 **Benefit:** 75% = $45.00 85% = $51.00
Fee 15214	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit - each attendance at which treatment is given 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15211 plus for each field in excess of 1, an amount of $34.95
Fee 15215	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $65.30 **Benefit:** 75% = $49.00 85% = $55.55
Fee 15218	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $65.30 **Benefit:** 75% = $49.00 85% = $55.55
Fee 15221	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast)

T2. RADIATION ONCOLOGY	3. MEGAVOLTAGE
	Fee: $65.30 **Benefit:** 75% = $49.00 85% = $55.55
Fee 15224	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221 **Fee:** $65.30 **Benefit:** 75% = $49.00 85% = $55.55
Fee 15227	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $65.30 **Benefit:** 75% = $49.00 85% = $55.55
Fee 15230	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15215 plus for each field in excess of 1, an amount of $41.60
Fee 15233	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15218 plus for each field in excess of 1, an amount of $41.60
Fee 15236	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15221 plus for each field in excess of 1, an amount of $41.60
Fee 15239	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15230, 15233 or 15236 **Derived Fee:** The fee for item 15224 plus for each field in excess of 1, an amount of $41.60
Fee 15242	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15227 plus for each field in excess of 1, an amount of $41.60
Fee 15245	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $65.30 **Benefit:** 75% = $49.00 85% = $55.55
Fee 15248	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $65.30 **Benefit:** 75% = $49.00 85% = $55.55

T2. RADIATION ONCOLOGY	3. MEGAVOLTAGE
Fee 15251	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $65.30 **Benefit:** 75% = $49.00 85% = $55.55
Fee 15254	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15245, 15248 or 15251 **Fee:** $65.30 **Benefit:** 75% = $49.00 85% = $55.55
Fee 15257	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $65.30 **Benefit:** 75% = $49.00 85% = $55.55
Fee 15260	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) **Derived Fee:** The fee for item 15245 plus for each field in excess of 1, an amount of $41.60
Fee 15263	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15248 plus for each field in excess of 1, an amount of $41.60
Fee 15266	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15251 plus for each field in excess of 1, an amount of $41.60
Fee 15269	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266 **Derived Fee:** The fee for item 15254 plus for each field in excess of 1, an amount of $41.60
Fee 15272	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15257 plus for each field in excess of 1, an amount of $41.60
Fee 15275	RADIATION ONCOLOGY TREATMENT with IGRT imaging facilities undertaken: (a) to implement an IMRT dosimetry plan prepared in accordance with item 15565; and

T2. RADIATION ONCOLOGY	3. MEGAVOLTAGE
	(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. **Fee:** $200.35 **Benefit:** 75% = $150.30 85% = $170.30

T2. RADIATION ONCOLOGY	4. BRACHYTHERAPY
	Group T2. Radiation Oncology
	Subgroup 4. Brachytherapy
Fee 15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $391.00 **Benefit:** 75% = $293.25 85% = $332.35
Fee 15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $391.00 **Benefit:** 75% = $293.25 85% = $332.35
Fee 15307	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $741.25 **Benefit:** 75% = $555.95 85% = $648.05
Fee 15308	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $741.25 **Benefit:** 75% = $555.95 85% = $648.05
Fee 15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $365.00 **Benefit:** 75% = $273.75 85% = $310.25
Fee 15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $362.30 **Benefit:** 75% = $271.75 85% = $308.00
Fee 15315	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $716.50 **Benefit:** 75% = $537.40 85% = $623.30
Fee 15316	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $716.50 **Benefit:** 75% = $537.40 85% = $623.30
Fee 15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $444.70 **Benefit:** 75% = $333.55 85% = $378.00

T2. RADIATION ONCOLOGY	4. BRACHYTHERAPY
Fee 15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $444.70 **Benefit:** 75% = $333.55 85% = $378.00
Fee 15323	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $790.75 **Benefit:** 75% = $593.10 85% = $697.55
Fee 15324	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $790.75 **Benefit:** 75% = $593.10 85% = $697.55
Fee 15327	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $860.25 **Benefit:** 75% = $645.20 85% = $767.05
Fee 15328	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $860.25 **Benefit:** 75% = $645.20 85% = $767.05
Fee 15331	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $816.80 **Benefit:** 75% = $612.60 85% = $723.60
Fee 15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $816.80 **Benefit:** 75% = $612.60 85% = $723.60
Fee 15335	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $741.25 **Benefit:** 75% = $555.95 85% = $648.05
Fee 15336	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $741.25 **Benefit:** 75% = $555.95 85% = $648.05
Fee 15338	Prostate, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance:

	(a) for a patient with: (i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate); and (ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and (iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and (b) performed by an oncologist at an approved site in association with a urologist; and (c) being a service associated with: (i) services to which items 37220 and 55603 apply; and (ii) a service to which item 60506 or 60509 applies (See para TN.2.2 of explanatory notes to this Category) **Fee:** $1,024.70 **Benefit:** 75% = $768.55 85% = $931.50
Fee 15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.) **Fee:** $83.40 **Benefit:** 75% = $62.55 85% = $70.90
Fee 15342	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of greater than 115 days, to treat intracavity, intraoral or intranasal site **Fee:** $208.40 **Benefit:** 75% = $156.30 85% = $177.15
Fee 15345	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites **Fee:** $556.10 **Benefit:** 75% = $417.10 85% = $472.70
Fee 15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance **Fee:** $63.95 **Benefit:** 75% = $48.00 85% = $54.40
Fee 15351	CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface **Fee:** $127.75 **Benefit:** 75% = $95.85 85% = $108.60
Fee 15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface **Fee:** $154.95 **Benefit:** 75% = $116.25 85% = $131.75
Fee 15357	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD, attendance upon a patient to apply a radioactive mould constructed for application to an external surface of the patient other than an attendance which is the first attendance to apply the mould each attendance **Fee:** $43.80 **Benefit:** 75% = $32.85 85% = $37.25

	Group T2. Radiation Oncology
	Subgroup 5. Computerised Planning
	RADIOTHERAPY PLANNING
Fee 15500	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $265.80 **Benefit:** 75% = $199.35 85% = $225.95
Fee 15503	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15512 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $341.25 **Benefit:** 75% = $255.95 85% = $290.10
Fee 15506	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15515 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $509.60 **Benefit:** 75% = $382.20 85% = $433.20
Fee 15509	RADIATION FIELD SETTING using a diagnostic xray unit of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15500 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $230.30 **Benefit:** 75% = $172.75 85% = $195.80
Fee 15512	RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $296.90 **Benefit:** 75% = $222.70 85% = $252.40
Fee 15513	RADIATION SOURCE LOCALISATION using a simulator or x-ray machine or CT of a single area, where views in more than 1 plane are required, for brachytherapy treatment planning for I125 seed implantation of localised prostate cancer, in association with item 15338 (See para TN.2.3 of explanatory notes to this Category) **Fee:** $335.70 **Benefit:** 75% = $251.80 85% = $285.35
Fee 15515	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $429.95 **Benefit:** 75% = $322.50 85% = $365.50
Fee 15518	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks

	(See para TN.2.3 of explanatory notes to this Category) **Fee:** $84.35 **Benefit:** 75% = $63.30 85% = $71.70
Fee 15521	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used (See para TN.2.3 of explanatory notes to this Category) **Fee:** $372.30 **Benefit:** 75% = $279.25 85% = $316.50
Fee 15524	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields (See para TN.2.3 of explanatory notes to this Category) **Fee:** $698.00 **Benefit:** 75% = $523.50 85% = $604.80
Fee 15527	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks (See para TN.2.3 of explanatory notes to this Category) **Fee:** $86.45 **Benefit:** 75% = $64.85 85% = $73.50
Fee 15530	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used (See para TN.2.3 of explanatory notes to this Category) **Fee:** $385.65 **Benefit:** 75% = $289.25 85% = $327.85
Fee 15533	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields (See para TN.2.3 of explanatory notes to this Category) **Fee:** $731.30 **Benefit:** 75% = $548.50 85% = $638.10
Fee 15536	BRACHYTHERAPY PLANNING, computerised radiation dosimetry (See para TN.2.3 of explanatory notes to this Category) **Fee:** $292.30 **Benefit:** 75% = $219.25 85% = $248.50
Fee 15539	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338 (See para TN.2.3 of explanatory notes to this Category) **Fee:** $687.00 **Benefit:** 75% = $515.25 85% = $593.80
Fee 15550	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY without intravenous contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and

	(d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images (See para TN.2.3 of explanatory notes to this Category) **Fee:** $721.30 **Benefit:** 75% = $541.00 85% = $628.10
Fee 15553	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY pre and post intravenous contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images (See para TN.2.3 of explanatory notes to this Category) **Fee:** $778.25 **Benefit:** 75% = $583.70 85% = $685.05
Fee 15555	SIMULATION FOR INTENSITY-MODULATED RADIATION THERAPY (IMRT), with or without intravenous contrast medium, if: 1. treatment set-up and technique specifications are in preparations for three-dimensional conformal radiotherapy dose planning; and 2. patient set-up and immobilisation techniques are suitable for reliable CT-image volume data acquisition and three-dimensional conformal radiotherapy; and 3. a high-quality CT-image volume dataset is acquired for the relevant region of interest to be planned and treated; and 4. the image set is suitable for the generation of quality digitally-reconstructed radiographic images. (See para TN.2.3 of explanatory notes to this Category) **Fee:** $778.25 **Benefit:** 75% = $583.70 85% = $685.05
Fee 15556	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 1 COMPLEXITY where: (a) dosimetry for a single phase three dimensional conformal treatment plan using CT image volume dataset and having a single treatment target volume and organ at risk; and (b) one gross tumour volume or clinical target volume, plus one planning target volume plus at least one relevant organ at risk as defined in the prescription must be rendered as volumes; and (c) the organ at risk must be nominated as a planning dose goal or constraint and the prescription must specify the organ at risk dose goal or constraint; and (d) dose volume histograms must be generated, approved and recorded with the plan; and (e) a CT image volume dataset must be used for the relevant region to be planned and treated; and

	(f) the CT images must be suitable for the generation of quality digitally reconstructed radiographic images (See para TN.2.3 of explanatory notes to this Category) **Fee:** $727.70 **Benefit:** 75% = $545.80 85% = $634.50
Fee 15559	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 2 COMPLEXITY where: (a) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, two planning target volumes and one organ at risk defined in the prescription; or (b) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and two organ at risk dose goals or constraints defined in the prescription; or (c) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 1 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images (See para TN.2.3 of explanatory notes to this Category) **Fee:** $949.10 **Benefit:** 75% = $711.85 85% = $855.90
Fee 15562	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where: (a) dosimetry for a three or more phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, three planning target volumes and one organ at risk defined in the prescription; or (b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and (i) two planning target volumes; or (ii) two organ at risk dose goals or constraints defined in the prescription. or (c) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and three organ at risk dose goals or constraints defined in the prescription; or

	(d) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 2 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images (See para TN.2.3 of explanatory notes to this Category) **Fee:** $1,227.50 **Benefit:** 75% = $920.65 85% = $1134.30
Fee 15565	Preparation of an IMRT DOSIMETRY PLAN, which uses one or more CT image volume datasets, if: (a) in preparing the IMRT dosimetry plan: (i) the differential between target dose and normal tissue dose is maximised, based on a review and assessment by a radiation oncologist; and (ii) all gross tumour targets, clinical targets, planning targets and organs at risk are rendered as volumes as defined in the prescription; and (iii) organs at risk are nominated as planning dose goals or constraints and the prescription specifies the organs at risk as dose goals or constraints; and (iv) dose calculations and dose volume histograms are generated in an inverse planned process, using a specialised calculation algorithm, with prescription and plan details approved and recorded in the plan; and (v) a CT image volume dataset is used for the relevant region to be planned and treated; and (vi) the CT images are suitable for the generation of quality digitally reconstructed radiographic images; and (b) the final IMRT dosimetry plan is validated by the radiation therapist and the medical physicist, using robust quality assurance processes that include: (i) determination of the accuracy of the dose fluence delivered by the multi-leaf collimator and gantryposition (static or dynamic); and (ii) ensuring that the plan is deliverable, data transfer is acceptable and validation checks are 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:** $3,629.35 **Benefit:** 75% = $2722.05 85% = $3536.15

T2. RADIATION ONCOLOGY	6. STEREOTACTIC RADIOSURGERY
	Group T2. Radiation Oncology
	Subgroup 6. Stereotactic Radiosurgery
Fee 15600	STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment **Fee:** $1,864.45 **Benefit:** 75% = $1398.35 85% = $1771.25

T2. RADIATION ONCOLOGY	7. RADIATION ONCOLOGY TREATMENT VERIFICATION
	Group T2. Radiation Oncology
	Subgroup 7. Radiation Oncology Treatment Verification
Fee 15700	RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710 - each attendance at which treatment is verified (i.e. maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category) **Fee:** $50.35 **Benefit:** 75% = $37.80 85% = $42.80
Fee 15705	RADIATION ONCOLOGY TREATMENT VERIFICATION - multiple projection acquisition when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710 - each attendance at which treatment involving three or more fields is verified (i.e. maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category) **Fee:** $83.90 **Benefit:** 75% = $62.95 85% = $71.35
Fee 15710	RADIATION ONCOLOGY TREATMENT VERIFICATION - volumetric acquisition, when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15705 - each attendance at which treatment involving three fields or more is verified (i.e. maximum one per attendance). (see para T2.5 of explanatory notes to this Category) (See para TN.2.4 of explanatory notes to this Category) **Fee:** $83.90 **Benefit:** 75% = $62.95 85% = $71.35
Fee 15715	RADIATION ONCOLOGY TREATMENT VERIFICATION of planar or volumetric IGRT for IMRT, involving the use of at least 2 planar image views or projections or 1 volumetric image set to facilitate a 3-dimensional adjustment to radiation treatment field positioning, if: (a) the treatment technique is classified as IMRT; and (b) the margins applied to volumes (clinical target volume or planning target volume) are tailored or reduced to minimise treatment related exposure of healthy or normal tissues; and (c) the decisions made using acquired images are based on action algorithms and are given effect immediately prior to or during treatment delivery by qualified and trained staff considering complex competing factors and using software driven modelling programs; and (d) the radiation treatment field positioning requires accuracy levels of less than 5mm (curative cases) or up to 10mm (palliative cases) to ensure accurate dose delivery to the target; and

T2. RADIATION ONCOLOGY	7. RADIATION ONCOLOGY TREATMENT VERIFICATION
	(e) the image decisions and actions are documented in the patient's record; and (f) the radiation oncologist is responsible for supervising the process, including specifying the type and frequency of imaging, tolerance and action levels to be incorporated in the process, reviewing the trend analysis and any reports and relevant images during the treatment course and specifying action protocols as required; and (g) when treatment adjustments are inadequate to satisfy treatment protocol requirements, replanning is required; and (h) the imaging infrastructure (hardware and software) is linked to the treatment unit and networked to an image database, enabling both on line and off line reviews. (See para TN.2.4 of explanatory notes to this Category) **Fee:** $83.90 **Benefit:** 75% = $62.95 85% = $71.35

T2. RADIATION ONCOLOGY	8. BRACHYTHERAPY PLANNING AND VERIFICATION
	Group T2. Radiation Oncology
	Subgroup 8. Brachytherapy Planning And Verification
Fee 15800	BRACHYTHERAPY TREATMENT VERIFICATION - maximum of one only for each attendance. (See para TN.2.4 of explanatory notes to this Category) **Fee:** $105.45 **Benefit:** 75% = $79.10 85% = $89.65
Fee 15850	RADIATION SOURCE LOCALISATION using a simulator, x-ray machine, CT or ultrasound of a single area, where views in more than one plane are required, for brachytherapy treatment planning, not being a service to which Item 15513 applies. **Fee:** $218.50 **Benefit:** 75% = $163.90 85% = $185.75

T2. RADIATION ONCOLOGY	10. TARGETED INTRAOPERATIVE RADIOTHERAPY
	Group T2. Radiation Oncology
	Subgroup 10. Targeted Intraoperative Radiotherapy
	INTRAOPERATIVE RADIOTHERAPY
Fee 15900	BREAST, MALIGNANT TUMOUR, targeted intraoperative radiation therapy, using an Intrabeam® or Xoft® Axxent® device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who: 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

T2. RADIATION ONCOLOGY	10. TARGETED INTRAOPERATIVE RADIOTHERAPY
	e) has a node negative malignancy; and f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and g) has no contra-indications to breast irradiation Applicable only once per breast per lifetime (H) **Fee:** $273.75 **Benefit:** 75% = $205.35

T3. THERAPEUTIC NUCLEAR MEDICINE	
	Group T3. Therapeutic Nuclear Medicine
Amend Fee 16003	Intra-cavitary administration of a therapeutic dose of Yttrium 90 (not including preliminary paracentesis and other than a service to which item 35404, 35406 or 35408 applies or a service associated with selective internal radiation therapy) (Anaes.) (See para TN.3.1 of explanatory notes to this Category) **Fee:** $1,554.25 **Benefit:** 75% = $1165.70 85% = $1461.05
Amend Fee 16006	Administration of a therapeutic dose of Iodine 131 for thyroid cancer by single dose technique **Fee:** $1,047.70 **Benefit:** 75% = $785.80 85% = $954.50
Amend Fee 16009	Administration of a therapeutic dose of Iodine 131 for thyrotoxicosis by single dose technique **Fee:** $507.55 **Benefit:** 75% = $380.70 85% = $431.45
Amend Fee 16012	Intravenous administration of a therapeutic dose of Phosphorous 32 **Fee:** $2,915.10 **Benefit:** 75% = $2186.35 85% = $2821.90
Amend Fee 16015	Administration of Strontium 89 for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if systemic antineoplastic therapy is unavailable or has failed to control the patient's disease and either: a) the disease is poorly controlled by conventional radiotherapy; or b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain. **Fee:** $4,474.70 **Benefit:** 75% = $3356.05 85% = $4381.50
Amend Fee 16018	Administration of ^{153} Sm-lexidronam for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if systemic antineoplastic therapy is unavailable or has failed to control the patient's disease, and: a) the disease is poorly controlled by conventional radiotherapy; or b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain. **Fee:** $4,814.70 **Benefit:** 75% = $3611.05 85% = $4721.50

T4. OBSTETRICS	
	Group T4. Obstetrics

T4. OBSTETRICS	
Fee 16400	ANTENATAL CARE Antenatal service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitionerif: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; (b) the service is provided at, or from, a practice location in a regional, rural or remote area; (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day); (d) the service is not provided for an admitted patient of a hospital; and to a maximum of 10 service per pregnancy (See para TN.4.1, TN.4.15 of explanatory notes to this Category) **Fee:** $29.85 **Benefit:** 85% = $25.40 **Extended Medicare Safety Net Cap:** $12.50
Fee 16401	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 (See para TN.4.2 of explanatory notes to this Category) **Fee:** $93.65 **Benefit:** 75% = $70.25 85% = $79.65 **Extended Medicare Safety Net Cap:** $62.10
Fee 16404	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance SUBSEQUENT to the first attendance in a single course of treatment. (See para AN.0.70, TN.4.2 of explanatory notes to this Category) **Fee:** $47.10 **Benefit:** 75% = $35.35 85% = $40.05 **Extended Medicare Safety Net Cap:** $37.20
Fee 16406	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 **Fee:** $146.75 **Benefit:** 75% = $110.10 85% = $124.75 **Extended Medicare Safety Net Cap:** $122.20
Fee 16407	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 (See para TN.4.13, TN.4.15 of explanatory notes to this Category) **Fee:** $78.55 **Benefit:** 75% = $58.95 85% = $66.80 **Extended Medicare Safety Net Cap:** $51.10
Fee 16408	Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance: (a) is by:

	(i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner; and (b) is between 1 week and 4 weeks after the birth; and (c) lasts at least 20 minutes; and (d) is for a patient who was privately admitted for the birth; and (e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided Payable once only for a pregnancy (See para TN.4.15 of explanatory notes to this Category) **Fee:** $58.50 **Benefit:** 85% = $49.75 **Extended Medicare Safety Net Cap:** $38.05
Fee 16500	ANTENATAL ATTENDANCE (See para TN.4.3, TN.4.15 of explanatory notes to this Category) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95 **Extended Medicare Safety Net Cap:** $37.20
Fee 16501	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy (See para TN.4.3, TN.4.4 of explanatory notes to this Category) **Fee:** $153.95 **Benefit:** 75% = $115.50 85% = $130.90 **Extended Medicare Safety Net Cap:** $74.40
Fee 16502	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day (See para TN.4.3 of explanatory notes to this Category) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95 **Extended Medicare Safety Net Cap:** $24.80
Fee 16505	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance (See para TN.4.3 of explanatory notes to this Category) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95 **Extended Medicare Safety Net Cap:** $24.80
Fee 16508	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

T4. OBSTETRICS	
	(See para TN.4.3 of explanatory notes to this Category) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95 **Extended Medicare Safety Net Cap:** $24.80
Fee 16509	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 (See para TN.4.3 of explanatory notes to this Category) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95 **Extended Medicare Safety Net Cap:** $24.80
Fee 16511	CERVIX, purse string ligation of (Anaes.) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $240.85 **Benefit:** 75% = $180.65 85% = $204.75 **Extended Medicare Safety Net Cap:** $124.00
Fee 16512	CERVIX, removal of purse string ligature of (Anaes.) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $69.50 **Benefit:** 75% = $52.15 85% = $59.10 **Extended Medicare Safety Net Cap:** $37.20
Fee 16514	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $40.15 **Benefit:** 75% = $30.15 85% = $34.15 **Extended Medicare Safety Net Cap:** $18.60
Fee 16515	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.) (See para TN.4.5, TN.4.10 of explanatory notes to this Category) **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $597.70 **Extended Medicare Safety Net Cap:** $198.50
Fee 16518	Management of labour, incomplete, if the patient's care has been transferred to another medical practitioner for completion of the birth (Anaes.) (See para TN.4.5, TN.4.10 of explanatory notes to this Category) **Fee:** $493.55 **Benefit:** 75% = $370.20 85% = $419.55 **Extended Medicare Safety Net Cap:** $198.50
Fee 16519	Management of labour and birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.) (See para TN.4.5, TN.4.6, TN.4.10 of explanatory notes to this Category) **Fee:** $760.05 **Benefit:** 75% = $570.05 85% = $666.85 **Extended Medicare Safety Net Cap:** $372.10
Fee 16520	Caesarean section and post-operative care for 7 days, if the patient’s care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.) (See para TN.4.6, TN.4.10 of explanatory notes to this Category) **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $597.70 **Extended Medicare Safety Net Cap:** $372.10

T4. OBSTETRICS	
	Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days: (a) fetal loss; (b) multiple pregnancy; (c) antepartum haemorrhage that is: (i) of greater than 200 ml; or (ii) associated with disseminated intravascular coagulation; (d) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal cervical os; (e) baby with a birth weight less than or equal to 2,500 g; (f) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section; (g) trial of vaginal breech birth where there has been a planned vaginal breech birth; (h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical dilatation and effacement until full dilatation of the cervix); (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 x 10^9/L; or
Fee 16522	(iv) uric acid greater than 0.36 mmol/L;

T4. OBSTETRICS	
	(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 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:** $1,784.50 **Benefit:** 75% = $1338.40

T4. OBSTETRICS	
Fee 16527	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.) (See para TN.4.8 of explanatory notes to this Category) **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $597.70 **Extended Medicare Safety Net Cap:** $198.50
Fee 16528	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.) (See para TN.4.8 of explanatory notes to this Category) **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $597.70 **Extended Medicare Safety Net Cap:** $372.10
Fee 16530	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.) (See para TN.4.5 of explanatory notes to this Category) **Fee:** $420.95 **Benefit:** 75% = $315.75 85% = $357.85 **Extended Medicare Safety Net Cap:** $273.65
Fee 16531	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.) (See para TN.4.5, TN.4.14 of explanatory notes to this Category) **Fee:** $841.90 **Benefit:** 75% = $631.45
Fee 16533	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 (See para TN.4.3, TN.4.14 of explanatory notes to this Category) **Fee:** $115.60 **Benefit:** 75% = $86.70
Fee 16534	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 (See para TN.4.3, TN.4.14 of explanatory notes to this Category) **Fee:** $115.60 **Benefit:** 75% = $86.70
Fee 16564	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.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $238.75 **Benefit:** 75% = $179.10 85% = $202.95 **Extended Medicare Safety Net Cap:** $248.10
Fee 16567	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $349.15 **Benefit:** 75% = $261.90 85% = $296.80 **Extended Medicare Safety Net Cap:** $248.10

T4. OBSTETRICS	
Fee 16570	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $455.70 **Benefit:** 75% = $341.80 85% = $387.35 **Extended Medicare Safety Net Cap:** $248.10
Fee 16571	CERVIX, repair of extensive laceration or lacerations (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $349.15 **Benefit:** 75% = $261.90 85% = $296.80 **Extended Medicare Safety Net Cap:** $248.10
Fee 16573	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $284.50 **Benefit:** 75% = $213.40 85% = $241.85 **Extended Medicare Safety Net Cap:** $248.10
Fee 16590	Planning and management, by a practitioner, of a pregnancy if: (a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and (b) the patient intends to be privately admitted for the birth; and (c) the pregnancy has progressed beyond 28 weeks gestation; and (d) the practitioner has maternity privileges at a hospital or birth centre; and (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:** $408.25 **Benefit:** 75% = $306.20 85% = $347.05 **Extended Medicare Safety Net Cap:** $248.10
Fee 16591	Planning and management, by a practitioner, of a pregnancy if: (a) the pregnancy has progressed beyond 28 weeks gestation; and (b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (c) a service to which item 16590 applies is not provided in relation to the same pregnancy Payable once only for a pregnancy (See para TN.4.13, TN.4.9 of explanatory notes to this Category) **Fee:** $156.20 **Benefit:** 75% = $117.15 85% = $132.80 **Extended Medicare Safety Net Cap:** $124.00
Fee 16600	INTERVENTIONAL TECHNIQUES

T4. OBSTETRICS	
	AMNIOCENTESIS, diagnostic (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $69.50 **Benefit:** 75% = $52.15 85% = $59.10 **Extended Medicare Safety Net Cap:** $37.20
Fee 16603	CHORIONIC VILLUS SAMPLING, by any route (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $133.50 **Benefit:** 75% = $100.15 85% = $113.50 **Extended Medicare Safety Net Cap:** $74.40
Fee 16606	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:** $266.40 **Benefit:** 75% = $199.80 85% = $226.45 **Extended Medicare Safety Net Cap:** $148.90
Fee 16609	FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.) (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $543.25 **Benefit:** 75% = $407.45 85% = $461.80 **Extended Medicare Safety Net Cap:** $285.40
Fee 16612	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.) (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $427.40 **Benefit:** 75% = $320.55 85% = $363.30
Fee 16615	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.) (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $227.65 **Benefit:** 75% = $170.75 85% = $193.55
Fee 16618	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $227.65 **Benefit:** 75% = $170.75 85% = $193.55 **Extended Medicare Safety Net Cap:** $117.90
Fee 16621	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $227.65 **Benefit:** 75% = $170.75 85% = $193.55
Fee 16624	FOETAL FLUID FILLED CAVITY, drainage of (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $327.65 **Benefit:** 75% = $245.75 85% = $278.55 **Extended Medicare Safety Net Cap:** $161.30

T4. OBSTETRICS	
Fee 16627	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $667.00 **Benefit:** 75% = $500.25 85% = $573.80 **Extended Medicare Safety Net Cap:** $347.40

T4. OBSTETRICS	1. OBSTETRIC TELEHEALTH SERVICES
	Group T4. Obstetrics
	Subgroup 1. Obstetric telehealth services
Amend Fee 91850	Antenatal telehealth service provided by a practice midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, to a maximum of 10 services per pregnancy, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is not performed in conjunction with another antenatal attendance item in Group T4 for the same patient on the same day by the same practitioner. **Fee:** $29.85 **Benefit:** 85% = $25.40 **Extended Medicare Safety Net Cap:** $12.50
Fee 91851	Postnatal telehealth attendance by an obstetrician or general practitioner (other than a service to which any other item applies) if: (a) is between 4 and 8 weeks after the birth; and (b) lasts at least 20 minutes in duration; and (c) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (d) is for a pregnancy in relation to which a service to which item 82140 applies is not provided. Applicable once for a pregnancy **Fee:** $78.55 **Benefit:** 85% = $66.80 **Extended Medicare Safety Net Cap:** $52.80
Fee 91852	Postnatal telehealth attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if: (a) the attendance is rendered by: (i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or

T4. OBSTETRICS	1. OBSTETRIC TELEHEALTH SERVICES
	(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, 82140, 91214, 91215, 91221 or 91222 is not provided. Applicable once for a pregnancy **Fee:** $58.50 **Benefit:** 85% = $49.75 **Extended Medicare Safety Net Cap:** $39.30
Fee 91853	Antenatal telehealth attendance. **Fee:** $51.65 **Benefit:** 85% = $43.95 **Extended Medicare Safety Net Cap:** $37.20

T4. OBSTETRICS	2. OBSTETRIC PHONE SERVICES
	Group T4. Obstetrics
	Subgroup 2. Obstetric phone services
Amend Fee 91855	Antenatal phone service provided by a practice midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, to a maximum of 10 services per pregnancy, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is not performed in conjunction with another antenatal attendance item in Group T4 for the same patient on the same day by the same practitioner. **Fee:** $29.85 **Benefit:** 85% = $25.40 **Extended Medicare Safety Net Cap:** $12.50
Fee 91856	Postnatal phone attendance by an obstetrician or general practitioner (other than a service to which any other item applies) if: (a) is between 4 and 8 weeks after the birth; and (b) lasts at least 20 minutes in duration; and

T4. OBSTETRICS	2. OBSTETRIC PHONE SERVICES
	(c) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (d) is for a pregnancy in relation to which a service to which item 82140 applies is not provided. Applicable once for a pregnancy **Fee:** $78.55 **Benefit:** 85% = $66.80 **Extended Medicare Safety Net Cap:** $52.80
Fee 91857	Postnatal phone attendance other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if: (a) the attendance is rendered by: (i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner; and (b) is between 1 week and 4 weeks after the birth; and (c) lasts at least 20 minutes; and (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, 82140, 91214, 91215, 91221 or 91222 is not provided. Applicable once for a pregnancy **Fee:** $58.50 **Benefit:** 85% = $49.75 **Extended Medicare Safety Net Cap:** $39.30
Fee 91858	Antenatal phone attendance. **Fee:** $51.65 **Benefit:** 85% = $43.95 **Extended Medicare Safety Net Cap:** $37.20

T6. ANAESTHETICS	1. ANAESTHESIA CONSULTATIONS
	Group T6. Anaesthetics
	Subgroup 1. Anaesthesia Consultations

T6. ANAESTHETICS	1. ANAESTHESIA CONSULTATIONS
Fee 17610	ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION (Professional attendance by a medical practitioner in the practice of ANAESTHESIA) - a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system) - *AND of not more than 15 minutes s duration*, not being a service associated with a service to which items 2801 - 3000 apply (See para TN.6.1 of explanatory notes to this Category) **Fee:** $47.80 **Benefit:** 75% = $35.85 85% = $40.65 **Extended Medicare Safety Net Cap:** $143.40
Fee 17615	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 (See para TN.6.1 of explanatory notes to this Category) **Fee:** $95.10 **Benefit:** 75% = $71.35 85% = $80.85 **Extended Medicare Safety Net Cap:** $285.30
Fee 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 management plan documented in the patient notes - and of more than 30 minutes but not more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply (See para TN.6.1 of explanatory notes to this Category) **Fee:** $131.75 **Benefit:** 75% = $98.85 85% = $112.00 **Extended Medicare Safety Net Cap:** $395.25
Fee 17625	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems , the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes - and of more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply (See para TN.6.1 of explanatory notes to this Category) **Fee:** $167.75 **Benefit:** 75% = $125.85 85% = $142.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 17640	ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia)

	(Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her) - a BRIEF consultation involving a short history and limited examination - *AND of not more than 15 minutes duration*, not being a service associated with a service to which items 2801 - 3000 apply (See para TN.6.2 of explanatory notes to this Category) **Fee:** $47.80 **Benefit:** 75% = $35.85 85% = $40.65 **Extended Medicare Safety Net Cap:** $143.40
Fee 17645	- a consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan - *AND of more than 15 minutes but not more than 30 minutes duration,* not being a service associated with a service to which items 2801 - 3000 apply. (See para TN.6.2 of explanatory notes to this Category) **Fee:** $95.10 **Benefit:** 75% = $71.35 85% = $80.85 **Extended Medicare Safety Net Cap:** $285.30
Fee 17650	- a consultation involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan - *AND of more than 30 minutes but not more than 45 minutes duration,* not being a service associated with a service to which items 2801 - 3000 apply (See para TN.6.2 of explanatory notes to this Category) **Fee:** $131.75 **Benefit:** 75% = $98.85 85% = $112.00 **Extended Medicare Safety Net Cap:** $395.25
Fee 17655	- a consultation involving an exhaustive history and comprehensive examination of multiple systems and the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity, - *AND of more than 45 minutes duration,* not being a service associated with a service to which items 2801 - 3000 apply. (See para TN.6.2 of explanatory notes to this Category) **Fee:** $167.75 **Benefit:** 75% = $125.85 85% = $142.60 **Extended Medicare Safety Net Cap:** $500.00
Fee 17680	ANAESTHETIST, CONSULTATION, OTHER

T6. ANAESTHETICS	1. ANAESTHESIA CONSULTATIONS
	(Professional attendance by an anaesthetist in the practice of ANAESTHESIA) - a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 - 3000 apply. (See para TN.6.3 of explanatory notes to this Category) **Fee:** $95.10 **Benefit:** 75% = $71.35 85% = $80.85 **Extended Medicare Safety Net Cap:** $285.30
Fee 17690	- Where a pre-anaesthesia consultation covered by an item in the range 17615-17625 is performed in-rooms if: (a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and (b) the service is not provided to an admitted patient of a hospital; and (c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and (d) the service is of more than 15 minutes duration not being a service associated with a service to which items 2801 - 3000 apply. (See para TN.6.3 of explanatory notes to this Category) **Fee:** $43.95 **Benefit:** 75% = $33.00 85% = $37.40 **Extended Medicare Safety Net Cap:** $131.85

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Group T7. Regional Or Field Nerve Blocks
Fee 18213	Intravenous regional anaesthesia of limb by retrograde perfusion of local anaesthetic agent **Fee:** $97.05 **Benefit:** 75% = $72.80 85% = $82.50
Fee 18216	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.) (See para TN.10.7 of explanatory notes to this Category)

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Fee: $208.00 **Benefit:** 75% = $156.00 85% = $176.80
Fee 18219	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by the medical practitioner extends beyond the first hour (Anaes.) (See para TN.10.7 of explanatory notes to this Category) **Derived Fee:** The fee for item 18216 plus $20.80 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.
Fee 18222	Continuous infusion or injection by catheter of a therapeutic substance (not contrast agent) to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is 15 minutes or less (See para TN.7.2, TN.10.7 of explanatory notes to this Category) **Fee:** $41.25 **Benefit:** 75% = $30.95 85% = $35.10
Fee 18225	Continuous infusion or injection by catheter of a therapeutic substance (not contrast agent) to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is more than 15 minutes (See para TN.7.2, TN.10.7 of explanatory notes to this Category) **Fee:** $54.80 **Benefit:** 75% = $41.10 85% = $46.60
Fee 18226	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 (See para TN.7.4, TN.10.7 of explanatory notes to this Category) **Fee:** $311.95 **Benefit:** 75% = $234.00 85% = $265.20
Fee 18227	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. (See para TN.7.4, TN.10.7 of explanatory notes to this Category) **Derived Fee:** The fee for item 18226 plus $31.35 for each additional 15 minutes or part there of beyond the first hour of attendance by the medical practitioner.
Fee 18228	Interpleural block, initial injection or commencement of infusion of a therapeutic substance, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (See para TN.7.1 of explanatory notes to this Category) **Fee:** $68.50 **Benefit:** 75% = $51.40 85% = $58.25
Fee 18230	Intrathecal or epidural injection of neurolytic substance (not contrast agent) by any route, including transforaminal route (Anaes.) (See para TN.7.3 of explanatory notes to this Category) **Fee:** $261.10 **Benefit:** 75% = $195.85 85% = $221.95
Fee 18232	Intrathecal or epidural injection (including translaminar and transforaminal approaches) of therapeutic substance or substances (anaesthetic, steroid or chemotherapeutic agents): (a) other than a service to which another item in this Group applies; and

T7. REGIONAL OR FIELD NERVE BLOCKS	
	(b) not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.) (See para TN.7.3, TN.7.1 of explanatory notes to this Category) **Fee:** $208.00 **Benefit:** 75% = $156.00 85% = $176.80
Fee 18233	EPIDURAL INJECTION of blood for blood patch (Anaes.) **Fee:** $208.00 **Benefit:** 75% = $156.00 85% = $176.80
Fee 18234	Trigeminal nerve, primary branch (ophthalmic, maxillary or mandibular branches, excluding infraorbital nerve), injection of an anaesthetic agent or steroid, but not in association with a service to which an item in Group T8 applies, unless a targeted percutaneous technique is used (Anaes.) (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18236	Trigeminal nerve, peripheral branch (including infraorbital nerve), injection of an anaesthetic agent, but not in association with a service to which an item in Group T8 applies, unless a targeted percutaneous technique is used (Anaes.) (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $68.50 **Benefit:** 75% = $51.40 85% = $58.25
Fee 18238	Facial nerve, injection of an anaesthetic agent, other than a service associated with a service to which item 18240 applies, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $41.25 **Benefit:** 75% = $30.95 85% = $35.10
Fee 18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $102.50 **Benefit:** 75% = $76.90 85% = $87.15
Fee 18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $41.25 **Benefit:** 75% = $30.95 85% = $35.10
Fee 18244	Vagus nerve, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $110.45 **Benefit:** 75% = $82.85 85% = $93.90
Fee 18248	PHRENIC NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $97.05 **Benefit:** 75% = $72.80 85% = $82.50
Fee 18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $68.50 **Benefit:** 75% = $51.40 85% = $58.25

T7. REGIONAL OR FIELD NERVE BLOCKS	
Fee 18252	Cervical plexus, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $110.45 **Benefit:** 75% = $82.85 85% = $93.90
Fee 18254	Brachial plexus, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $110.45 **Benefit:** 75% = $82.85 85% = $93.90
Fee 18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $68.50 **Benefit:** 75% = $51.40 85% = $58.25
Fee 18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $68.50 **Benefit:** 75% = $51.40 85% = $58.25
Fee 18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $97.05 **Benefit:** 75% = $72.80 85% = $82.50
Fee 18262	Ilio inguinal, iliohypogastric or genitofemoral nerves, one or more of, injections of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.) (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $68.50 **Benefit:** 75% = $51.40 85% = $58.25
Fee 18264	Pudendal nerve or dorsal nerve (or both), injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $110.45 **Benefit:** 75% = $82.85 85% = $93.90
Fee 18266	Ulnar, radial or median nerve, main trunk of, one or more of, injections of an anaesthetic agent, not being associated with a brachial plexus block, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $68.50 **Benefit:** 75% = $51.40 85% = $58.25
Fee 18268	OBTURATOR NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $97.05 **Benefit:** 75% = $72.80 85% = $82.50
Fee 18270	FEMORAL NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $97.05 **Benefit:** 75% = $72.80 85% = $82.50
Fee 18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category)

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Fee: $68.50 **Benefit:** 75% = $51.40 85% = $58.25
Fee 18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18278	Sciatic nerve, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $97.05 **Benefit:** 75% = $72.80 85% = $82.50
Fee 18280	Sphenopalatine ganglion, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.) (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure (See para TN.7.5 of explanatory notes to this Category) **Fee:** $110.45 **Benefit:** 75% = $82.85 85% = $93.90
Fee 18284	Cervical or thoracic sympathetic chain, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $161.65 **Benefit:** 75% = $121.25 85% = $137.45
Fee 18286	Lumbar or pelvic sympathetic chain, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $161.65 **Benefit:** 75% = $121.25 85% = $137.45
Fee 18288	Coeliac plexus or splanchnic nerves, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $161.65 **Benefit:** 75% = $121.25 85% = $137.45
Fee 18290	Cranial nerve other than trigeminal, destruction by a neurolytic agent under image guidance, other than a service associated with the injection of botulinum toxin (Anaes.) (See para TN.7.6 of explanatory notes to this Category) **Fee:** $273.50 **Benefit:** 75% = $205.15 85% = $232.50
Fee 18292	Nerve branch, destruction by a neurolytic agent under image guidance, other than a service to which another item in this Group applies or a service associated with the injection of botulinum toxin except a service to which item 18354 applies (Anaes.) (See para TN.7.5, TN.7.6 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18294	Coeliac plexus or splanchnic nerves, destruction by a neurolytic agent under image guidance (Anaes.) (See para TN.7.6 of explanatory notes to this Category)

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Fee: $192.80 **Benefit:** 75% = $144.60 85% = $163.90
Fee 18296	Lumbar or pelvic sympathetic chain, destruction by a neurolytic agent under image guidance (Anaes.) (See para TN.7.6 of explanatory notes to this Category) **Fee:** $164.90 **Benefit:** 75% = $123.70 85% = $140.20
Fee 18297	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25
Fee 18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $192.80 **Benefit:** 75% = $144.60 85% = $163.90

T8. SURGICAL OPERATIONS	1. GENERAL
	Group T8. Surgical Operations
	Subgroup 1. General
30001	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds (See para TN.8.5 of explanatory notes to this Category) **Derived Fee:** 50% of the fee which would have applied had the procedure not been discontinued
Amend **Fee** 30003	Burns, involving 1% or more but less than 3% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy **Fee:** $39.80 **Benefit:** 75% = $29.85 85% = $33.85
Amend **Fee** 30006	Burns, involving 3% or more but less than 10% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy **Fee:** $50.90 **Benefit:** 75% = $38.20 85% = $43.30
New 30007	Burns, involving 10% or more of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy **Fee:** $170.20 **Benefit:** 75% = $127.65 85% = $144.70
Amend **Fee** 30010	Burns, involving not more than 3% of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) **Fee:** $81.00 **Benefit:** 75% = $60.75
Amend **Fee** 30014	Burns, involving 3% or more but less than 20% of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.)

	Fee: $170.20 **Benefit:** 75% = $127.65
New 30015	Burns, involving 20% or more but less than 50% of total body surface, or burns of less than 20% of total body surface involving 1% or more of total body surface within the hands or face, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) (Assist.) **Fee:** $255.30 **Benefit:** 75% = $191.50
New 30016	Burns, involving 50% or more of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) (Assist.) **Fee:** $382.95 **Benefit:** 75% = $287.25
Fee 30023	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) (See para TN.8.6, TN.8.200 of explanatory notes to this Category) **Fee:** $357.10 **Benefit:** 75% = $267.85 85% = $303.55
Fee 30024	WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical incision or Fournier's Gangrene, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) **Fee:** $357.10 **Benefit:** 75% = $267.85 85% = $303.55
Fee 30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $57.20 **Benefit:** 75% = $42.90 85% = $48.65
Fee 30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $98.60 **Benefit:** 75% = $73.95 85% = $83.85
Fee 30032	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $90.30 **Benefit:** 75% = $67.75 85% = $76.80
Fee 30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
Fee 30038	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.)

	(See para TN.8.6 of explanatory notes to this Category) **Fee:** $98.60 **Benefit:** 75% = $73.95 85% = $83.85
Fee 30042	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, other than on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, other than a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $203.25 **Benefit:** 75% = $152.45 85% = $172.80
Fee 30045	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
Fee 30049	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $203.25 **Benefit:** 75% = $152.45 85% = $172.80
Fee 30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) **Fee:** $278.15 **Benefit:** 75% = $208.65 85% = $236.45
Fee 30055	Wounds, dressing of, under general, regional or intravenous sedation, with or without removal of sutures, other than a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85
Fee 30058	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.) **Fee:** $158.10 **Benefit:** 75% = $118.60 85% = $134.40
Fee 30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.) **Fee:** $25.75 **Benefit:** 75% = $19.35 85% = $21.90
Fee 30062	Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.) **Fee:** $66.50 **Benefit:** 75% = $49.90 85% = $56.55
Fee 30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.) **Fee:** $120.35 **Benefit:** 75% = $90.30 85% = $102.30
Fee 30068	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $303.15 **Benefit:** 75% = $227.40 85% = $257.70

Fee 30071	Diagnostic biopsy of skin, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $57.20 **Benefit:** 75% = $42.90 85% = $48.65 **Extended Medicare Safety Net Cap:** $45.80
Fee 30072	Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $57.20 **Benefit:** 75% = $42.90 85% = $48.65
Fee 30075	DIAGNOSTIC BIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) **Fee:** $164.05 **Benefit:** 75% = $123.05 85% = $139.45
Fee 30078	DIAGNOSTIC DRILL BIOPSY OF LYMPH NODE, DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $53.10 **Benefit:** 75% = $39.85 85% = $45.15
Fee 30081	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $120.35 **Benefit:** 75% = $90.30 85% = $102.30
Fee 30084	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $64.45 **Benefit:** 75% = $48.35 85% = $54.80
Fee 30087	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $32.20 **Benefit:** 75% = $24.15 85% = $27.40
Fee 30090	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $140.80 **Benefit:** 75% = $105.60 85% = $119.70
Fee 30093	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $187.90 **Benefit:** 75% = $140.95 85% = $159.75
Fee 30094	DIAGNOSTIC PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imaging techniques - but not including imaging, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $207.45 **Benefit:** 75% = $155.60 85% = $176.35

Fee 30097	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented, if: a. serum cortisol at 0830-0930 hours on any day in the preceding month has been measured at greater than 100 nmol/L but less than 400 nmol/L; or b. in a patient who is acutely unwell and adrenal insufficiency is suspected. (See para TN.8.139 of explanatory notes to this Category) **Fee:** $106.40 **Benefit:** 75% = $79.80 85% = $90.45
Fee 30099	SINUS, excision of, involving superficial tissue only (Anaes.) **Fee:** $98.60 **Benefit:** 75% = $73.95 85% = $83.85
Fee 30103	SINUS, excision of, involving muscle and deep tissue (Anaes.) **Fee:** $201.40 **Benefit:** 75% = $151.05 85% = $171.20
Fee 30104	Pre-auricular sinus, excision of, on a patient 10 years of age or over (Anaes.) **Fee:** $139.05 **Benefit:** 75% = $104.30 85% = $118.20
Fee 30105	Pre-auricular sinus, excision of, on a patient under 10 years of age (Anaes.) **Fee:** $180.70 **Benefit:** 75% = $135.55 85% = $153.60
Fee 30107	Excision of ganglion, other than a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $240.85 **Benefit:** 75% = $180.65 85% = $204.75
New 30166	Removal of redundant abdominal skin and lipectomy, as a wedge excision, for functional problems following significant weight loss equivalent to at least 5 body mass index points and if there has been a stable weight for a period of at least 6 months prior to surgery, other than a service associated with a service to which item 30175, 30176, 30177, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies (H) (Anaes.) (Assist.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $821.45 **Benefit:** 75% = $616.10
New 30169	Removal of redundant non-abdominal skin and lipectomy for functional problems following significant weight loss equivalent to at least 5 body mass index points and if there has been a stable weight for a period of at least 6 months prior to surgery, one or 2 non-abdominal areas, other than a service associated with a service to which item 30175, 30176, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies (H) (Anaes.) (Assist.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $657.15 **Benefit:** 75% = $492.90
Amend **Fee** 30175 S	Radical abdominoplasty, with repair of rectus diastasis, excision of skin and subcutaneous tissue, and transposition of umbilicus, not being a laparoscopic procedure, if: (a) the patient has an abdominal wall defect as a consequence of pregnancy; and (b) the patient: (i) has a diastasis of at least 3cm measured by diagnostic imaging prior to this service; and (ii) has either or both of the following:

	(A) at least moderately severe pain or discomfort at the site of the diastasis in the abdominal wall during functional use and the pain or discomfort has been documented in the patient's records by the practitioner providing the service; (B) low back pain or urinary symptoms likely due to rectus diastasis and the pain or symptoms have been documented in the patient's records by the practitioner providing the service; and (iii) has failed to respond to non-surgical conservative treatment, that must have included physiotherapy; and (iv) has not been pregnant in the last 12 months; and (c) the service is not a service associated with a service to which item 30166, 30169, 30176, 30177, 30179, 30651, 30655, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies Applicable once per lifetime (H) (Anaes.) (Assist.) (See para TN.8.8, TN.8.97, TN.8.276 of explanatory notes to this Category) **Fee:** $1,062.50 **Benefit:** 75% = $796.90
Amend Fee 30176	Radical abdominoplasty, with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30166, 30169, 30175, 30177, 30179, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (H) (Anaes.) (Assist.) (See para TN.8.97 of explanatory notes to this Category) **Fee:** $1,079.50 **Benefit:** 75% = $809.65
Amend Fee 30177	Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdominal skin and fat that is a direct consequence of significant weight loss, in conjunction with a radical abdominoplasty, with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30166, 30175, 30176, 30179, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $1,079.50 **Benefit:** 75% = $809.65
Amend Fee 30179	Circumferential lipectomy, as an independent procedure, to correct circumferential excess of redundant skin and fat that is a direct consequence of significant weight loss, with or without a radical abdominoplasty, not being a service associated with a service to which item 30175, 30176, 30177, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies, if:

	(a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $1,328.65 **Benefit:** 75% = $996.50
Fee 30180	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.) **Fee:** $149.50 **Benefit:** 75% = $112.15 85% = $127.10
Fee 30183	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $229.50
Fee 30187	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $281.45 **Benefit:** 75% = $211.10 85% = $239.25
Fee 30189	WARTS or MOLLUSCUM CONTAGIOSUM (one or more), removal of, by any method (other than by chemical means), where undertaken in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (H) (Anaes.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $161.30 **Benefit:** 75% = $121.00
Fee 30190	Angiofibromas, trichoepitheliomas or other severely disfiguring tumours of the face or neck (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), suitable for laser ablation as confirmed by the opinion of a specialist in the specialty of dermatology—removal of, by carbon dioxide laser or erbium laser ablation, including associated resurfacing (10 or more tumours) (Anaes.) **Fee:** $435.60 **Benefit:** 75% = $326.70 85% = $370.30
Fee 30191	Angiofibromas, trichoepithelioma, epidermal naevi, xanthelasma, pyogenic granuloma, genital angiokeratomas, hereditary haemorrhagic telangiectasia and other severely disfiguring or recurrently bleeding tumours (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), treatment of, with carbon dioxide/erbium 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. **Fee:** $69.50 **Benefit:** 75% = $52.15 85% = $59.10
Fee 30192	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $43.30 **Benefit:** 75% = $32.50 85% = $36.85

	Malignant neoplasm of skin or mucous membrane that has been: (a) proven by histopathology; or (b) confirmed by the opinion of a specialist in the specialty of dermatology or plastic surgery where a specimen has been submitted for histologic confirmation; removal of, by serial curettage, or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy (Anaes.)
Fee 30196	(See para TN.8.10 of explanatory notes to this Category) **Fee:** $138.25 **Benefit:** 75% = $103.70 85% = $117.55
	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinion of a specialist in the specialty of dermatology or plastic surgery—removal of, by liquid nitrogen cryotherapy using repeat freeze thaw cycles
Fee 30202	(See para TN.8.10 of explanatory notes to this Category) **Fee:** $52.95 **Benefit:** 75% = $39.75 85% = $45.05
	Skin lesions, multiple injections with glucocorticoid preparations (Anaes.)
Fee 30207	**Fee:** $48.85 **Benefit:** 75% = $36.65 85% = $41.55
	Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparations, if undertaken in the operating theatre of a hospital (H) (Anaes.)
Fee 30210	**Fee:** $178.45 **Benefit:** 75% = $133.85
	HAEMATOMA, aspiration of (Anaes.)
Fee 30216	**Fee:** $29.95 **Benefit:** 75% = $22.50 85% = $25.50
	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)
Fee 30219	(See para TN.8.4 of explanatory notes to this Category) **Fee:** $29.95 **Benefit:** 75% = $22.50 85% = $25.50
	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.)
Fee 30223	(See para TN.8.4 of explanatory notes to this Category) **Fee:** $178.45 **Benefit:** 75% = $133.85
	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.)
Fee 30224	**Fee:** $260.20 **Benefit:** 75% = $195.15 85% = $221.20
	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.)
Fee 30225	**Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25
	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.)
Fee 30226	**Fee:** $164.05 **Benefit:** 75% = $123.05 85% = $139.45
	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.)
Fee 30229	**Fee:** $298.95 **Benefit:** 75% = $224.25 85% = $254.15

Fee 30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $244.90 **Benefit:** 75% = $183.70 85% = $208.20
Fee 30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) **Fee:** $323.85 **Benefit:** 75% = $242.90 85% = $275.30
Fee 30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.) **Fee:** $164.05 **Benefit:** 75% = $123.05 85% = $139.45
Fee 30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $390.30 **Benefit:** 75% = $292.75 85% = $331.80
Fee 30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) **Fee:** $390.30 **Benefit:** 75% = $292.75
Fee 30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $755.50 **Benefit:** 75% = $566.65
Fee 30247	Parotid gland, total extirpation of, including removal of tumour, other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.) (See para TN.8.254 of explanatory notes to this Category) **Fee:** $809.75 **Benefit:** 75% = $607.35
Fee 30250	Parotid gland, total extirpation of, with preservation of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.) (See para TN.8.254 of explanatory notes to this Category) **Fee:** $1,370.20 **Benefit:** 75% = $1027.65
Fee 30251	Recurrent parotid tumour, excision of, with preservation of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.) (See para TN.8.254 of explanatory notes to this Category) **Fee:** $2,104.80 **Benefit:** 75% = $1578.60
Fee 30253	Parotid gland, superficial lobectomy of, with exposure of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve;

	other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.) (See para TN.8.254 of explanatory notes to this Category) **Fee:** $913.50 **Benefit:** 75% = $685.15
Fee 30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $1,216.40 **Benefit:** 75% = $912.30
Fee 30256	Submandibular gland, extirpation of, other than a service associated with a service to which item 31423, 31426, 31429, 31432, 31435 or 31438 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $487.85 **Benefit:** 75% = $365.90
Fee 30257 S	Sialendoscopy, of submandibular or parotid duct, with or without removal of calculus or treatment of stricture (Anaes.) **Fee:** $547.60 **Benefit:** 75% = $410.70 85% = $465.50
Fee 30259	SUBLINGUAL GLAND, extirpation of (Anaes.) **Fee:** $217.45 **Benefit:** 75% = $163.10 85% = $184.85
Fee 30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $64.45 **Benefit:** 75% = $48.35 85% = $54.80
Fee 30266	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) **Fee:** $164.05 **Benefit:** 75% = $123.05 85% = $139.45
Fee 30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) **Fee:** $164.05 **Benefit:** 75% = $123.05 85% = $139.45
Fee 30272	TONGUE, partial excision of (Anaes.) (Assist.) **Fee:** $323.85 **Benefit:** 75% = $242.90 85% = $275.30
Fee 30275	Radical excision of intra oral tumour, with or without resection of mandible, including dissection of lymph glands of neck, unilateral, other than a service associated with a service to which item 31423, 31426, 31429, 31432, 31435 or 31438 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.261 of explanatory notes to this Category) **Fee:** $1,930.60 **Benefit:** 75% = $1447.95
Fee 30278	Tongue tie, repair of, other than: (a) a service to which another item in this Subgroup applies; or (b) a service associated with a service to which item 45009 applies (Anaes.) **Fee:** $50.90 **Benefit:** 75% = $38.20 85% = $43.30
Fee 30281	Tongue tie, mandibular frenulum or maxillary frenulum, repair of, in a person aged 2 years and over, under general anaesthesia, other than a service associated with a service to which item 45009 applies (Anaes.) **Fee:** $130.85 **Benefit:** 75% = $98.15 85% = $111.25

Fee 30283	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $224.20 **Benefit:** 75% = $168.15 85% = $190.60
Fee 30286	Branchial cyst, removal of, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $435.70 **Benefit:** 75% = $326.80 85% = $370.35
Fee 30287	Branchial cyst, removal of, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $566.50 **Benefit:** 75% = $424.90 85% = $481.55
Fee 30289	Branchial fistula, removal of, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $550.05 **Benefit:** 75% = $412.55
Fee 30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.) **Fee:** $487.85 **Benefit:** 75% = $365.90 85% = $414.70
Fee 30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) **Fee:** $1,930.60 **Benefit:** 75% = $1447.95
Fee 30296	THYROIDECTOMY, total (Anaes.) (Assist.) (See para TN.8.137 of explanatory notes to this Category) **Fee:** $1,121.20 **Benefit:** 75% = $840.90
Fee 30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) (See para TN.8.138 of explanatory notes to this Category) **Fee:** $1,121.20 **Benefit:** 75% = $840.90
Amend Fee 30299	Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in an axilla, using preoperative lymphoscintigraphy and/or lymphotropic dye injection (H) (Anaes.) (Assist.) **Fee:** $777.85 **Benefit:** 75% = $583.40
New 30305	Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection along internal mammary chain (H) (Anaes.) (Assist.) **Fee:** $777.90 **Benefit:** 75% = $583.45
Fee 30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) (See para TN.8.137, TN.8.138 of explanatory notes to this Category) **Fee:** $874.70 **Benefit:** 75% = $656.05
Fee 30310	Partial or subtotal thyroidectomy (Anaes.) (Assist.) (See para TN.8.137 of explanatory notes to this Category) **Fee:** $874.70 **Benefit:** 75% = $656.05
Amend Fee 30311 S	Sentinel lymph node biopsy or biopsies for cutaneous melanoma, using preoperative lymphoscintigraphy and/or lymphotropic dye injection, if: (a) the primary lesion is greater than 1.0 mm in depth (or at least 0.8 mm in depth in the presence of ulceration); and

	(b) appropriate excision of the primary melanoma has occurred; and (c) the service is not associated with a service to which item 30075, 30078, 30299, 30305, 30329, 30332, 30618, 30820, 31423, 52025 or 52027 applies Applicable to only one lesion per occasion on which the service is provided (H) (Anaes.) (Assist.) **Fee:** $681.70 **Benefit:** 75% = $511.30
Fee 30314	Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $500.90 **Benefit:** 75% = $375.70
Fee 30315	Minimally invasive parathyroidectomy. Removal of 1 or more parathyroid adenoma through a small cervical incision for an image localised adenoma, including thymectomy. 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. (Anaes.) (Assist.) **Fee:** $1,248.50 **Benefit:** 75% = $936.40
Fee 30317	Redo parathyroidectomy. Cervical re-exploration for persistent or recurrent hyperparathyroidism, including thymectomy and cervical exploration of the mediastinum. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30315, 30318 or 30320 applies. (Anaes.) (Assist.) **Fee:** $1,494.85 **Benefit:** 75% = $1121.15
Fee 30318	Open parathyroidectomy, exploration and removal of 1 or more adenoma or hyperplastic glands via a cervical incision including thymectomy and cervical exploration of the mediastinum when performed. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30315, 30317 or 30320 applies. (Anaes.) (Assist.) **Fee:** $1,248.50 **Benefit:** 75% = $936.40
Fee 30320	Removal of a mediastinal parathyroid adenoma via sternotomy or mediastinal thorascopic approach. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30315, 30317 or 30318 applies. (Anaes.) (Assist.) **Fee:** $1,494.85 **Benefit:** 75% = $1121.15
Fee 30323	Excision of phaeochromocytoma or extraadrenal paraganglioma via endoscopic or open approach. (Anaes.) (Assist.) **Fee:** $1,494.85 **Benefit:** 75% = $1121.15
Fee 30324	Excision of an adrenocortical tumour or hyperplasia via endoscopic or open approach. (Anaes.) (Assist.) **Fee:** $1,494.85 **Benefit:** 75% = $1121.15
Fee 30326	Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a patient under 10 years of age (Anaes.) (Assist.)

	Fee: $651.20 **Benefit:** 75% = $488.40
Fee 30329	LYMPH NODES of GROIN, limited excision of (Anaes.) **Fee:** $270.45 **Benefit:** 75% = $202.85 85% = $229.90
Fee 30330	LYMPH NODES of GROIN, radical excision of (Anaes.) (Assist.) **Fee:** $787.15 **Benefit:** 75% = $590.40
Amend Fee 30332	Lymph nodes of axilla, limited excision of (H) (Anaes.) (Assist.) **Fee:** $379.75 **Benefit:** 75% = $284.85
Amend Fee 30336	Lymph nodes of axilla, complete excision of (H) (Anaes.) (Assist.) **Fee:** $1,139.30 **Benefit:** 75% = $854.50
Fee 30382	Enterocutaneous fistula, repair of, if dissection and resection of bowel is performed, with or without anastomosis or formation of a stoma (H) (Anaes.) (Assist.) **Fee:** $1,431.35 **Benefit:** 75% = $1073.55
Fee 30384	Open or minimally invasive excision of a retroperitoneal mass, 4 cm or greater in largest dimension, lasting more than 3 hours, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.) **Fee:** $1,494.85 **Benefit:** 75% = $1121.15
Fee 30385	Unplanned return to theatre for laparotomy or laparoscopy for control or drainage of intra-abdominal haemorrhage following abdominal surgery (H) (Anaes.) (Assist.) **Fee:** $617.00 **Benefit:** 75% = $462.75
Fee 30387	Laparoscopy or laparotomy when an operation is performed on abdominal, retroperitoneal or pelvic viscera, excluding lymph node biopsy, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.) **Fee:** $695.45 **Benefit:** 75% = $521.60
Fee 30388	Laparotomy for abdominal trauma, including control of haemorrhage (with or without packing) and containment of contamination (H) (Anaes.) (Assist.) **Fee:** $1,166.50 **Benefit:** 75% = $874.90
Fee 30390	Laparoscopy, diagnostic, with or without aspiration of fluid, on a patient 10 years of age or over, if no other intra-abdominal procedure is performed (H) (Anaes.) (Assist.) (See para TN.8.15 of explanatory notes to this Category) **Fee:** $240.85 **Benefit:** 75% = $180.65
Fee 30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) **Fee:** $738.75 **Benefit:** 75% = $554.10
Fee 30396	Laparotomy or laparoscopy for generalised intra-peritoneal sepsis (also known as peritonitis), with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity, with or without closure of the abdomen when performed by laparotomy (H) (Anaes.) (Assist.) **Fee:** $1,113.35 **Benefit:** 75% = $835.05

Fee 30397	Laparostomy, via wound previously made and left open or closed, including change of dressings or packs, with or without drainage of loculated collections (H) (Anaes.) **Fee:** $254.45 **Benefit:** 75% = $190.85
Fee 30399	Laparostomy, final closure of wound made at previous operation, after removal of dressings or packs (Anaes.) (Assist.) **Fee:** $349.95 **Benefit:** 75% = $262.50
Fee 30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) **Fee:** $692.70 **Benefit:** 75% = $519.55
Fee 30406	PARACENTESIS ABDOMINIS (Anaes.) **Fee:** $57.20 **Benefit:** 75% = $42.90 85% = $48.65
Fee 30408	PERITONEOVENOUS shunt, insertion of (Anaes.) (Assist.) **Fee:** $429.45 **Benefit:** 75% = $322.10
Fee 30409	LIVER BIOPSY, percutaneous (Anaes.) **Fee:** $191.05 **Benefit:** 75% = $143.30 85% = $162.40
Fee 30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) **Fee:** $97.25 **Benefit:** 75% = $72.95
Fee 30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) **Fee:** $57.35 **Benefit:** 75% = $43.05 85% = $48.75
Fee 30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.) **Fee:** $755.50 **Benefit:** 75% = $566.65
Fee 30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,510.80 **Benefit:** 75% = $1133.10
Fee 30416	Liver cysts, greater than 5 cm in diameter, marsupialisation of 4 or less (Anaes.) (Assist.) **Fee:** $820.25 **Benefit:** 75% = $615.20
Fee 30417	Liver cysts, greater than 5 cm in diameter, marsupialisation of 5 or more (Anaes.) (Assist.) **Fee:** $1,230.35 **Benefit:** 75% = $922.80
Fee 30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,749.70 **Benefit:** 75% = $1312.30
Fee 30419	Liver tumour, other than a hepatocellular carcinoma, destruction of one or more, by local ablation, other than a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.) **Fee:** $894.90 **Benefit:** 75% = $671.20 85% = $801.70

Fee 30421	Liver, extended lobectomy of, or central resections of segments 4, 5 and 8, other than for trauma (Anaes.) (Assist.) **Fee:** $2,186.75 **Benefit:** 75% = $1640.10
Fee 30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) **Fee:** $739.65 **Benefit:** 75% = $554.75
Fee 30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) **Fee:** $1,431.35 **Benefit:** 75% = $1073.55
Fee 30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.) **Fee:** $1,709.65 **Benefit:** 75% = $1282.25
Fee 30428	LIVER, lobectomy of, for trauma (Anaes.) (Assist.) **Fee:** $1,829.00 **Benefit:** 75% = $1371.75 85% = $1735.80
Fee 30430	Liver, extended lobectomy of, or central resections of segments 4, 5 and 8, for trauma (Anaes.) (Assist.) **Fee:** $2,544.50 **Benefit:** 75% = $1908.40 85% = $2451.30
Fee 30431	Liver abscess, single, open or minimally invasive abdominal drainage of, excluding aftercare (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25 85% = $485.35
Fee 30433	Liver abscess, multiple, open or minimally invasive abdominal drainage of, excluding aftercare (Anaes.) (Assist.) **Fee:** $795.20 **Benefit:** 75% = $596.40
Fee 30439	Intraoperative ultrasound of biliary tract, or operative cholangiography, if the service: (a) is performed in association with an intra-abdominal procedure; and (b) is not associated with a service to which item 30442 or 30445 applies (Anaes.) (Assist.) (See para TN.8.208 of explanatory notes to this Category) **Fee:** $203.25 **Benefit:** 75% = $152.45
Fee 30440	CHOLANGIOGRAM, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30451 applies (Anaes.) (Assist.) **Fee:** $576.50 **Benefit:** 75% = $432.40 85% = $490.05
Fee 30441	Intraoperative ultrasound for staging of intra-abdominal tumours (Anaes.) **Fee:** $149.25 **Benefit:** 75% = $111.95
Fee 30442	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.) (See para TN.8.208 of explanatory notes to this Category) **Fee:** $203.25 **Benefit:** 75% = $152.45
Fee 30443	Cholecystectomy, by any approach, without cholangiogram (Anaes.) (Assist.) **Fee:** $703.60 **Benefit:** 75% = $527.70

Fee 30445	Cholecystectomy, by any approach, with attempted or completed cholangiogram or intraoperative ultrasound of the biliary system, when performed via laparoscopic or open approach or when conversion from laparoscopic to open approach is required (Anaes.) (Assist.) (See para TN.8.208 of explanatory notes to this Category) **Fee:** $911.35 **Benefit:** 75% = $683.55
Fee 30448	Cholecystectomy, by any approach, involving removal of common duct calculi via the cystic duct, with or without stent insertion (Anaes.) (Assist.) (See para TN.8.208 of explanatory notes to this Category) **Fee:** $1,065.60 **Benefit:** 75% = $799.20
Fee 30449	Cholecystectomy with removal of common duct calculi via choledochotomy, by any approach, with or without insertion of a stent (Anaes.) (Assist.) (See para TN.8.208 of explanatory notes to this Category) **Fee:** $1,184.85 **Benefit:** 75% = $888.65
Fee 30450	Calculus of biliary tract, extraction of, using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $574.35 **Benefit:** 75% = $430.80 85% = $488.20
Fee 30451	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30440 applies (Anaes.) (Assist.) **Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25
Fee 30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.) **Fee:** $413.45 **Benefit:** 75% = $310.10
Fee 30454	Choledochotomy without cholecystectomy, with or without removal of calculi (Anaes.) (Assist.) **Fee:** $1,443.75 **Benefit:** 75% = $1082.85
Fee 30455	Choledochotomy with cholecystectomy, with removal of calculi, including biliary intestinal anastomosis (Anaes.) (Assist.) **Fee:** $1,443.75 **Benefit:** 75% = $1082.85
Fee 30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.) **Fee:** $1,510.80 **Benefit:** 75% = $1133.10 85% = $1417.60
Fee 30458	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.) (Assist.) **Fee:** $1,110.60 **Benefit:** 75% = $832.95
Fee 30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.) **Fee:** $944.60 **Benefit:** 75% = $708.45

Fee 30461	Radical resection of porta hepatis (including associated neuro-lymphatic tissue), for cancer, suspected cancer or choledochal cyst, including bile duct excision and biliary-enteric anastomoses, other than a service associated with a service to which item 30440, 30451 or 31454 applies (Anaes.) (Assist.) **Fee:** $1,619.15 **Benefit:** 75% = $1214.40
Fee 30463	Radical resection of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses, for cancer, suspected cancer or choledochal cyst (Anaes.) (Assist.) **Fee:** $1,988.05 **Benefit:** 75% = $1491.05
Fee 30464	Radical resection of common hepatic duct and right and left hepatic ducts, for cancer, suspected cancer or choledochal cyst, involving either or both of the following: (a) more than 2 anastomoses; (b) resection of segment (or major portion of segment) of liver; (Anaes.) (Assist.) **Fee:** $2,385.65 **Benefit:** 75% = $1789.25
Fee 30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.) **Fee:** $1,884.80 **Benefit:** 75% = $1413.60 85% = $1791.60
Fee 30472	Repair of bile duct injury, including immediate reconstruction, other than a service associated with a service to which item 30584 applies (Anaes.) (Assist.) **Fee:** $1,459.85 **Benefit:** 75% = $1094.90
Fee 30473	Oesophagoscopy (not being a service associated with a service to which item 41822 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30478 or 30479 applies. (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $194.00 **Benefit:** 75% = $145.50 85% = $164.90
Fee 30475	Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use of imaging intensification where clinically indicated) (Anaes.) (See para TN.8.17, TN.8.133 of explanatory notes to this Category) **Fee:** $382.20 **Benefit:** 75% = $286.65 85% = $324.90
Fee 30478	Oesophagoscopy (other than a service associated with a service to which item 41822 or 41825 applies), gastroscopy, duodenoscopy, panendoscopy or push enteroscopy, one or more such procedures, if: (a) the procedures are performed using one or more of the following endoscopic procedures: (i) polypectomy; (ii) sclerosing or adrenalin injections; (iii) banding; (iv) endoscopic clips; (v) haemostatic powders; (vi) diathermy; (vii) argon plasma coagulation; and

	(b) the procedures are for the treatment of one or more of the following: (i) upper gastrointestinal tract bleeding; (ii) polyps; (iii) removal of foreign body; (iv) oesophageal or gastric varices; (v) peptic ulcers; (vi) neoplasia; (vii) benign vascular lesions; (viii) strictures of the gastrointestinal tract; (ix) tumorous overgrowth through or over oesophageal stents; other than a service associated with a service to which item 30473 or 30479 applies (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $269.00 **Benefit:** 75% = $201.75 85% = $228.65
Fee 30479	Endoscopy with laser therapy, for the treatment of one or more of the following: (a) neoplasia; (b) benign vascular lesions; (c) strictures of the gastrointestinal tract; (d) tumorous overgrowth through or over oesophageal stents; (e) peptic ulcers; (f) angiodysplasia; (g) gastric antral vascular ectasia; (h) post-polypectomy bleeding; other than a service associated with a service to which item 30473 or 30478 applies (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $521.40 **Benefit:** 75% = $391.05 85% = $443.20
Fee 30481	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.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $391.00 **Benefit:** 75% = $293.25 85% = $332.35
Fee 30482	PERCUTANEOUS GASTROSTOMY (repeat procedure): (a) including any associated imaging services; and (b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.) **Fee:** $278.00 **Benefit:** 75% = $208.50 85% = $236.30
Fee 30483	Gastrostomy button, caecostomy antegrade enema device (chait etc.) or stomal indwelling device: (a) non-endoscopic insertion of; or (b) non-endoscopic replacement of; on a patient 10 years of age or over, excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.) **Fee:** $193.95 **Benefit:** 75% = $145.50 85% = $164.90
Fee 30484	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $399.70 **Benefit:** 75% = $299.80 85% = $339.75
Fee 30485	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $617.00 **Benefit:** 75% = $462.75 85% = $524.45
Fee 30488	SMALL BOWEL INTUBATION as an independent procedure (Anaes.) **Fee:** $98.60 **Benefit:** 75% = $73.95 85% = $83.85
Fee 30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $576.50 **Benefit:** 75% = $432.40 85% = $490.05
Fee 30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $608.25 **Benefit:** 75% = $456.20 85% = $517.05
Fee 30492	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $862.25 **Benefit:** 75% = $646.70
Fee 30494	ENDOSCOPIC BILIARY DILATATION (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $460.55 **Benefit:** 75% = $345.45
Fee 30495	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $862.25 **Benefit:** 75% = $646.70

Fee 30515	Gastroenterostomy (including gastroduodenostomy), enterocolostomy or enteroenterostomy, as an independent procedure or in combination with another procedure, only if required for irresectable obstruction, other than a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) **Fee:** $771.45 **Benefit:** 75% = $578.60
Fee 30517	Revision of gastroenterostomy, pyloroplasty or gastroduodenostomy (Anaes.) (Assist.) **Fee:** $1,010.00 **Benefit:** 75% = $757.50
Fee 30518	Partial gastrectomy, not being a service associated with a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) **Fee:** $1,081.55 **Benefit:** 75% = $811.20
Fee 30520	Gastric tumour, 2 cm or greater in diameter, removal of, by local excision, by laparoscopic or open approach, including any associated anastomosis, excluding polypectomy, other than a service to which item 30518 applies (Anaes.) (Assist.) **Fee:** $930.50 **Benefit:** 75% = $697.90
Fee 30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) **Fee:** $1,582.45 **Benefit:** 75% = $1186.85
Fee 30526	Gastrectomy, total, and removal of lower oesophagus, performed by open or minimally invasive approach, with anastomosis in the mediastinum, including any of the following (if performed): (a) distal pancreatectomy; (b) nodal dissection; (c) splenectomy (Anaes.) (Assist.) **Fee:** $2,361.65 **Benefit:** 75% = $1771.25
Fee 30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $1,431.35 **Benefit:** 75% = $1073.55
Fee 30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $858.90 **Benefit:** 75% = $644.20
Fee 30532	Oesophagogastric myotomy (Heller's operation) by endoscopic, abdominal or thoracic approach, whether performed by open or minimally invasive approach, including fundoplication when performed laparoscopically (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $986.15 **Benefit:** 75% = $739.65
Fee 30533	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $1,173.00 **Benefit:** 75% = $879.75
Fee 30559	OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.) **Fee:** $930.50 **Benefit:** 75% = $697.90 85% = $837.30

Fee 30560	Oesophageal perforation, repair of, by abdominal or thoracic approach, including thoracic drainage (Anaes.) (Assist.) **Fee:** $1,033.65 **Benefit:** 75% = $775.25
Fee 30562	Enterostomy or colostomy, closure of (not involving resection of bowel), on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $651.60 **Benefit:** 75% = $488.70
Fee 30563	COLOSTOMY OR ILEOSTOMY, refashioning of, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $651.60 **Benefit:** 75% = $488.70 85% = $558.40
Fee 30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.) **Fee:** $954.30 **Benefit:** 75% = $715.75
Fee 30574	NOTE: *Multiple Operation and Multiple Anaesthetic rules apply to this item* Appendicectomy, when performed in conjunction with another intra-abdominal procedure and during which a specimen is collected and sent for pathological testing (Anaes.) **Fee:** $67.50 **Benefit:** 75% = $50.65
Fee 30577	Initial pancreatic necrosectomy by open, laparoscopic or endoscopic approach, excluding aftercare (Anaes.) (Assist.) **Fee:** $1,192.90 **Benefit:** 75% = $894.70
Fee 30583	Distal pancreatectomy with splenic preservation, by open or minimally invasive approach (Anaes.) (Assist.) **Fee:** $1,702.40 **Benefit:** 75% = $1276.80
Fee 30584	Pancreatico duodenectomy (Whipple's procedure), with or without preservation of pylorus, including any of the following (if performed): (a) cholecystectomy; (b) pancreatico-biliary anastomosis; (c) gastro-jejunal anastomosis (Anaes.) (Assist.) **Fee:** $3,285.65 **Benefit:** 75% = $2464.25
Fee 30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.) **Fee:** $1,370.20 **Benefit:** 75% = $1027.65
Fee 30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.) **Fee:** $1,510.80 **Benefit:** 75% = $1133.10
Fee 30593	PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.) **Fee:** $2,067.50 **Benefit:** 75% = $1550.65 85% = $1974.30
Fee 30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.) **Fee:** $2,385.65 **Benefit:** 75% = $1789.25

Fee 30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.) **Fee:** $982.75 **Benefit:** 75% = $737.10
Fee 30599	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.) **Fee:** $1,431.35 **Benefit:** 75% = $1073.55
Fee 30600	Emergency repair of diaphragmatic laceration or hernia, following recent trauma, by any approach, including when performed in conjunction with another procedure indicated as a result of abdominal or chest trauma (Anaes.) (Assist.) **Fee:** $851.15 **Benefit:** 75% = $638.40
Fee 30601	Diaphragmatic hernia, congenital, or delayed presentation of traumatic rupture, repair of, by thoracic or abdominal approach, on a patient 10 years of age or over, other than a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) **Fee:** $1,048.50 **Benefit:** 75% = $786.40
Fee 30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.) **Fee:** $1,216.55 **Benefit:** 75% = $912.45
Fee 30608	Small intestine, resection of, with anastomosis, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $1,378.10 **Benefit:** 75% = $1033.60
Fee 30611	Benign tumour of soft tissue (other than tumours of skin, cartilage and bone, simple lipomas covered by item 31345 and lipomata), removal of, by surgical excision, on a patient under 10 years of age, if the specimen excised is sent for histological confirmation of diagnosis, other than a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $617.05 **Benefit:** 75% = $462.80 85% = $524.50
Fee 30615	Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 30618	Lymph nodes of neck, selective dissection of one or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a patient under 10 years of age (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $572.00 **Benefit:** 75% = $429.00 85% = $486.20
Fee 30619	Laparoscopic splenectomy, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $1,025.45 **Benefit:** 75% = $769.10
Fee 30621	Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or other repair, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service to which item 30651 or 30655 applies (Anaes.) (Assist.) **Fee:** $446.30 **Benefit:** 75% = $334.75
Fee 30622	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 patient under 10 years of age (Anaes.) (Assist.) (See para TN.8.14 of explanatory notes to this Category) **Fee:** $742.25 **Benefit:** 75% = $556.70
Fee 30623	Laparotomy involving division of peritoneal adhesions (if no other intra-abdominal procedure is performed), on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $742.25 **Benefit:** 75% = $556.70
Fee 30626	Laparotomy involving division of adhesions in association with another intra-abdominal procedure if the time taken to divide the adhesions is between 45 minutes and 2 hours, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $745.65 **Benefit:** 75% = $559.25
Fee 30627	Laparoscopy, diagnostic, if no other intra-abdominal procedure is performed, on a patient under 10 years of age (H) (Anaes.) (See para TN.8.15 of explanatory notes to this Category) **Fee:** $313.20 **Benefit:** 75% = $234.90
Fee 30628	HYDROCELE, tapping of **Fee:** $39.00 **Benefit:** 75% = $29.25 85% = $33.15
Fee 30629	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, without insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643 or 30644 applies (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Amend Fee 30630	Insertion of testicular prosthesis, at least 6 months following orchidectomy (H) (Anaes.) (Assist.) **Fee:** $518.90 **Benefit:** 75% = $389.20
Fee 30631	Hydrocele, removal of, other than a service associated with a service to which item 30641, 30642 or 30644 applies (Anaes.) **Fee:** $259.20 **Benefit:** 75% = $194.40 85% = $220.35
Fee 30635	Varicocele, surgical correction of, including microsurgical techniques, other than a service associated with a service to which item 30390, 30627, 30641, 30642 or 30644 applies—one procedure (Anaes.) (Assist.) **Fee:** $319.55 **Benefit:** 75% = $239.70
Fee 30636	Gastrostomy button, caecostomy antegrade enema device (chait etc.) or stomal indwelling device, non-endoscopic insertion of, or non-endoscopic replacement of, on a patient under 10 years of age (Anaes.) **Fee:** $255.35 **Benefit:** 75% = $191.55 85% = $217.05
Fee 30637	Enterostomy or colostomy, closure of (not involving resection of bowel), on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $847.25 **Benefit:** 75% = $635.45
Fee 30639	Colostomy or ileostomy, refashioning of, on a patient under 10 years of age (Anaes.) (Assist.)

	Fee: $847.25 **Benefit:** 75% = $635.45 85% = $754.05
Fee 30640	Repair of large and irreducible scrotal hernia, if surgery exceeds 2 hours, in a patient 10 years of age or over, other than a service to which item 30615, 30621, 30648, 30651 or 30655 applies (Anaes.) (Assist.) **Fee:** $1,002.10 **Benefit:** 75% = $751.60
Fee 30641	Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (H) (Anaes.) (Assist.) **Fee:** $446.30 **Benefit:** 75% = $334.75
Fee 30642	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, with insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643, 30644 or 45051 applies (Anaes.) (Assist.) **Fee:** $830.35 **Benefit:** 75% = $622.80
Fee 30643	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient under 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (Anaes.) (Assist.) **Fee:** $742.25 **Benefit:** 75% = $556.70
Fee 30644	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient at least 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 30645	Appendicectomy, on a patient under 10 years of age, other than a service to which item 30574 applies (Anaes.) (Assist.) **Fee:** $634.10 **Benefit:** 75% = $475.60
Fee 30646	Laparoscopic appendicectomy, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $634.10 **Benefit:** 75% = $475.60
Fee 30648	Femoral or inguinal hernia or infantile hydrocele, repair of, by open or minimally invasive approach, on a patient 10 years of age or over, other than a service to which item 30615 or 30651 applies (Anaes.) (Assist.) **Fee:** $508.80 **Benefit:** 75% = $381.60
Fee 30649	Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a patient under 10 years of age (Anaes.) **Fee:** $205.50 **Benefit:** 75% = $154.15 85% = $174.70
Amend Fee 30651	Ventral hernia repair involving primary fascial closure by suture, with or without onlay mesh or insertion of intraperitoneal onlay mesh repair, without closure of the defect or advancement of the rectus muscle toward the midline, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service associated with a service to which item 30175, 30621, 30655 or 30657 applies (H) (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 30652	Recurrent groin hernia regardless of size of defect, repair of, with or without mesh, by open or minimally invasive approach, in a patient 10 years of age or over (Anaes.) (Assist.)

	Fee: $570.95 **Benefit:** 75% = $428.25
Fee 30654	Circumcision of the penis, with topical or local analgesia, other than a service to which item 30658 applies **Fee:** $50.90 **Benefit:** 75% = $38.20 85% = $43.30
Amend Fee 30655	Ventral hernia, repair of, with advancement of the rectus muscles to the midline using a retro-rectus, pre-peritoneal or sublay technique, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service associated with a service to which item 30175, 30621 or 30651 applies (H) (Anaes.) (Assist.) **Fee:** $1,002.10 **Benefit:** 75% = $751.60
Fee 30657	Unilateral abdominal wall reconstruction with component separation, including transversus abdominus release and external oblique release for abdominal wall closure by mobilising the rectus abdominis muscles to the midline, by open or minimally invasive approach (Anaes.) (Assist.) **Fee:** $1,426.95 **Benefit:** 75% = $1070.25
Fee 30658	Circumcision of the penis, when performed under general or regional anaesthesia and in conjunction with a service to which an item in Group T7 or Group T10 applies (Anaes.) **Fee:** $155.45 **Benefit:** 75% = $116.60 85% = $132.15
Fee 30661	Minor surgical repair following a complication from the circumcision of a penis, when performed in conjunction with a service to which an item in Group T7 or Group T10 applies, other than a service associated with a service to which item 45206 applies (H) (Anaes.) (See para TN.8.252 of explanatory notes to this Category) **Fee:** $420.10 **Benefit:** 75% = $315.10
Fee 30662	Complex surgical repair following a complication from the circumcision of a penis, including single stage local flap, if indicated, to repair one defect, on genitals (other than a service associated with a service to which item 37819, 37822, 45200, 45201, 45202, 45203 or 45206 applies) (H) (Anaes.) (See para TN.8.252 of explanatory notes to this Category) **Fee:** $840.10 **Benefit:** 75% = $630.10
Fee 30663	Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a patient 10 years of age or over (Anaes.) **Fee:** $158.10 **Benefit:** 75% = $118.60 85% = $134.40
Fee 30666	PARAPHIMOSIS or PHIMOSIS, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
Fee 30672	COCCYX, excision of (Anaes.) (Assist.) **Fee:** $487.85 **Benefit:** 75% = $365.90
Fee 30676	Pilonidal sinus or cyst, or sacral sinus or cyst, definitive excision of (Anaes.) (See para TN.8.207 of explanatory notes to this Category) **Fee:** $415.15 **Benefit:** 75% = $311.40 85% = $352.90
Fee 30679	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.) **Fee:** $105.45 **Benefit:** 75% = $79.10 85% = $89.65

	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)
Fee 30680	(See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,281.45 **Benefit:** 75% = $961.10 85% = $1188.25
	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)
Fee 30682	(See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,281.45 **Benefit:** 75% = $961.10 85% = $1188.25
	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding.
Fee 30684	(Anaes.)

	(See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,576.95 **Benefit:** 75% = $1182.75 85% = $1483.75
	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)
Fee 30686	(See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,576.95 **Benefit:** 75% = $1182.75 85% = $1483.75
	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.)
Fee 30687	(See para TN.8.17, TN.8.20 of explanatory notes to this Category) **Fee:** $521.40 **Benefit:** 75% = $391.05 85% = $443.20
	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.)
Fee 30688	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $399.70 **Benefit:** 75% = $299.80 85% = $339.75
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
Fee 30690	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $617.00 **Benefit:** 75% = $462.75 85% = $524.45
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item 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.)
Fee 30692	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $399.70 **Benefit:** 75% = $299.80 85% = $339.75
Fee 30694	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in

	association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) (See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $617.00 **Benefit:** 75% = $462.75 85% = $524.45
Fee 30720	Appendicectomy, on a patient 10 years of age or over, whether performed by: (a) laparoscopy or right iliac fossa open incision; or (b) conversion of a laparoscopy to an open right iliac fossa incision; other than a service to which item 30574 applies (Anaes.) (Assist.) **Fee:** $487.85 **Benefit:** 75% = $365.90
Fee 30721	Laparotomy or laparoscopy, or laparoscopy converted to laparotomy, with or without associated biopsies, including the division of adhesions (if performed, but only if the time taken to divide adhesions is 45 minutes or less), if no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $529.30 **Benefit:** 75% = $397.00
Fee 30722	Laparotomy or laparoscopy, on a patient 10 years of age or over, including any of the following procedures (if performed, and including division of one or more adhesions, but only if the time taken to divide the adhesions is 45 minutes or less): (a) colostomy; (b) colotomy; (c) cholecystostomy; (d) enterostomy; (e) enterotomy; (f) gastrostomy; (g) gastrotomy; (h) caecostomy; (i) gastric fixation by cardiopexy; (j) reduction of intussusception; (k) simple repair of ruptured viscus (including perforated peptic ulcer); (l) reduction of volvulus; (m) drainage of pancreas (Anaes.) (Assist.) (See para TN.8.14 of explanatory notes to this Category) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 30723	Laparotomy, laparoscopy or extra-peritoneal approach, for drainage of an intra-abdominal, pancreatic or retroperitoneal collection or abscess (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 30724	Laparotomy or laparoscopy with division of adhesions, lasting more than 45 minutes but less than 2 hours, performed either: (a) as a primary procedure; or (b) when the division of adhesions is performed in conjunction with another primary procedure—to provide access to a surgical field (but excluding mobilisation or normal anatomical dissection of the organ or structure for which the primary procedure is being carried out) (Anaes.) (Assist.) **Fee:** $573.60 **Benefit:** 75% = $430.20
Fee 30725	Laparotomy or laparoscopy for intestinal obstruction or division of extensive, complex adhesions, lasting 2 hours or more, performed either: a) as a primary procedure; or b) when the division of adhesions is performed in conjunction with another procedure—to provide

	access to a surgical field, but excluding mobilisation or normal anatomical dissection of the organ or structure for which the other procedure is being carried out (Anaes.) (Assist.) **Fee:** $1,016.50 **Benefit:** 75% = $762.40
Fee 30730	Small intestine, resection of, including either of the following: (a) a small bowel diverticulum (such as Meckel's procedure) with anastomosis; (b) stricturoplasty (Anaes.) (Assist.) **Fee:** $1,060.05 **Benefit:** 75% = $795.05
Fee 30731	Intraoperative enterotomy for visualisation of the small intestine by endoscopy, including endoscopic examination using a flexible endoscope, with or without biopsies (Anaes.) (Assist.) **Fee:** $795.20 **Benefit:** 75% = $596.40
Fee 30732	Peritonectomy, lasting more than 5 hours, including hyperthermic intra-peritoneal chemotherapy (Anaes.) (Assist.) (See para TN.8.205 of explanatory notes to this Category) **Fee:** $4,353.60 **Benefit:** 75% = $3265.20
Fee 30750	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate) One surgeon (Anaes.) (Assist.) **Fee:** $2,258.65 **Benefit:** 75% = $1694.00
Fee 30751	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate) Conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,258.65 **Benefit:** 75% = $1694.00
Fee 30752	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate) Conjoint surgery, co-surgeon (Anaes.) (Assist.) **Fee:** $1,693.95 **Benefit:** 75% = $1270.50
Fee 30753	Oesophagectomy, by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chest One surgeon (Anaes.) (Assist.) **Fee:** $1,884.80 **Benefit:** 75% = $1413.60
Fee 30754	Oesophagectomy, by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chest Conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $1,884.80 **Benefit:** 75% = $1413.60
Fee 30755	Oesophagectomy by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and

	(b) anastomosis in the neck or chest Conjoint surgery, co-surgeon (Anaes.) (Assist.) **Fee:** $1,413.60 **Benefit:** 75% = $1060.20
Fee 30756	Antireflux operation by fundoplasty, with or without cardiopexy, by any approach, with or without closure of the diaphragmatic hiatus, other than a service to which item 30601 applies (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $954.30 **Benefit:** 75% = $715.75
Fee 30760	Vagotomy, with or without gastroenterostomy, pyloroplasty or other drainage procedure (Anaes.) (Assist.) **Fee:** $644.15 **Benefit:** 75% = $483.15
Fee 30761	Bleeding peptic ulcer, control of, by laparoscopy or laparotomy, involving suture of bleeding point or wedge excision (with or without gastric resection), including either of the following (if performed): (a) vagotomy and pyloroplasty; (b) gastroenterostomy (Anaes.) (Assist.) **Fee:** $831.00 **Benefit:** 75% = $623.25
Fee 30762	Gastrectomy, subtotal or total radical, for carcinoma, by open or minimally invasive approach, including all necessary anastomoses, including either or both of the following (if performed): (a) extended lymph node dissection; (b) splenectomy (Anaes.) (Assist.) **Fee:** $1,821.05 **Benefit:** 75% = $1365.80
Fee 30763	Gastric tumour, 2cm or greater in diameter, removal of, by local excision, by endoscopic approach, including any required anastomosis, excluding polypectomy, other than a service to which item 30518 applies (Anaes.) (Assist.) **Fee:** $739.65 **Benefit:** 75% = $554.75
Fee 30770	Hydatid cyst of liver, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Anaes.) (Assist.) **Fee:** $916.00 **Benefit:** 75% = $687.00
Fee 30771	Portal hypertension, porto-caval, meso-caval or selective spleno-renal shunt for (Anaes.) (Assist.) **Fee:** $1,847.50 **Benefit:** 75% = $1385.65
Fee 30780	Intrahepatic biliary bypass of left or right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,538.70 **Benefit:** 75% = $1154.05
Fee 30790	Pancreatic cyst anastomosis to stomach, duodenum or small intestine, by endoscopic, open or minimally invasive approach, with or without the use of endoscopic or intraoperative ultrasound (Anaes.) (Assist.) **Fee:** $768.10 **Benefit:** 75% = $576.10
Fee 30791	Pancreatic necrosectomy, by open, laparoscopic or endoscopic approach, excluding aftercare, subsequent procedure (Anaes.) (Assist.) **Fee:** $477.20 **Benefit:** 75% = $357.90

Fee 30792	Distal pancreatectomy with splenectomy, by open or minimally invasive approach (Anaes.) (Assist.) **Fee:** $1,308.00 **Benefit:** 75% = $981.00
Fee 30800	Splenectomy, by open or minimally invasive approach, other than a service to which item 30792 applies (Anaes.) (Assist.) **Fee:** $788.80 **Benefit:** 75% = $591.60
Fee 30810	Exploration of pancreas or duodenum for endocrine tumour, including associated imaging, either: (a) followed by local excision of tumour; or (b) when, after extensive exploration, no tumour is found (Anaes.) (Assist.) (See para TN.8.206 of explanatory notes to this Category) **Fee:** $1,256.45 **Benefit:** 75% = $942.35
Fee 30820	Lymph node of neck, biopsy of, by open procedure, if the specimen excised is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $201.40 **Benefit:** 75% = $151.05 85% = $171.20
Fee 31000	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer sections (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $636.20 **Benefit:** 75% = $477.15 85% = $543.00
Fee 31001	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—7 to 12 sections (inclusive) (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $795.20 **Benefit:** 75% = $596.40 85% = $702.00
Fee 31002	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 or more sections (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $954.30 **Benefit:** 75% = $715.75 85% = $861.10
Fee 31003	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer sections Not applicable to a service performed in association with a service to which item 31000 applies (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $636.20 **Benefit:** 75% = $477.15 85% = $543.00
Fee 31004	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the

	specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—7 to 12 sections (inclusive) Not applicable to a service performed in association with a service to which item 31001 applies (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $795.20 **Benefit:** 75% = $596.40 85% = $702.00
Fee 31005	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 or more sections Not applicable to a service performed in association with a service to which item 31002 applies (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $954.30 **Benefit:** 75% = $715.75 85% = $861.10
Fee 31206	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is not more than 10 mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.) **Fee:** $104.60 **Benefit:** 75% = $78.45 85% = $88.95
Fee 31211	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 10 mm, but not more than 20 mm, in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.) **Fee:** $134.85 **Benefit:** 75% = $101.15 85% = $114.65
Fee 31216	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 20 mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.) **Fee:** $157.25 **Benefit:** 75% = $117.95 85% = $133.70
Amend **Fee** 31220	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), lipomas, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if: (a) the size of each lesion is not more than 10 mm in diameter; and

	(b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and (c) all of the specimens excised are sent for histological examination (Anaes.) **Fee:** $234.95 **Benefit:** 75% = $176.25 85% = $199.75
Fee 31221	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); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.) **Fee:** $234.95 **Benefit:** 75% = $176.25 85% = $199.75
Amend Fee 31225	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), lipomas, 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.) **Fee:** $417.60 **Benefit:** 75% = $313.20 85% = $355.00
New 31227	Tumour, lipoma or cyst, removal of single lesion by excision and suture, where removal is from subcutaneous tissue and the specimen excised is sent for histological examination (Anaes.) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
Fee 31245	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HIDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes.) (See para TN.8.23 of explanatory notes to this Category) **Fee:** $404.10 **Benefit:** 75% = $303.10 85% = $343.50
Fee 31250	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface *where the specimen excised is sent for histological confirmation of diagnosis* (Anaes.) **Fee:** $404.10 **Benefit:** 75% = $303.10 85% = $343.50

Amend 31340	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, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383 is excised (Anaes.) **Derived Fee:** 75% of the fee for excision of malignant tumour
New 31344	Lipoma, removal of, by surgical excision or liposuction, if: (a) the lesion: (i) is subcutaneous and 150mm or more in diameter; or (ii) is submuscular, intramuscular or involves dissection of a named nerve or vessel and is 50 mm or more in diameter; and (b) a specimen of the excised lipoma is sent for histological confirmation of diagnosis (Anaes.) (Assist.) (See para TN.8.272 of explanatory notes to this Category) **Fee:** $691.90 **Benefit:** 75% = $518.95 85% = $598.70
Amend Fee 31345	Lipoma, removal of, by surgical excision or liposuction, if: (a) the lesion is: (i) subcutaneous and 50 mm or more in diameter but less than 150 mm in diameter; or (ii) sub fascial; and (b) the specimen excised is sent for histological confirmation of diagnosis (Anaes.) **Fee:** $231.05 **Benefit:** 75% = $173.30 85% = $196.40
Fee 31346	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.) (See para TN.8.101 of explanatory notes to this Category) **Fee:** $231.05 **Benefit:** 75% = $173.30 85% = $196.40
Fee 31350	Benign tumour of soft tissue (other than tumours of skin, cartilage and bone, simple lipomas covered by item 31345 and lipomata), removal of, by surgical excision, on a patient 10 years of age or over, if the specimen excised is sent for histological confirmation of diagnosis, other than a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $474.60 **Benefit:** 75% = $355.95 85% = $403.45

Fee 31355	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of by surgical excision, where *histological proof of malignancy has been obtained*, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $782.55 **Benefit:** 75% = $586.95 85% = $689.35
Amend Fee 31356	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $242.40 **Benefit:** 75% = $181.80 85% = $206.05
Fee 31357	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $120.10 **Benefit:** 75% = $90.10 85% = $102.10
Amend Fee 31358	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category)

	Fee: $296.65 **Benefit:** 75% = $222.50 85% = $252.20
Amend Fee 31359	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia (the applicable site); and (b) the necessary excision area is at least one third of the surface area of the applicable site; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (H) (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $361.60 **Benefit:** 75% = $271.20
Fee 31360	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $184.05 **Benefit:** 75% = $138.05 85% = $156.45
Amend Fee 31361	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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; 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:** $204.50 **Benefit:** 75% = $153.40 85% = $173.85
Fee 31362	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.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
Amend Fee 31363	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $267.50 **Benefit:** 75% = $200.65 85% = $227.40
Fee 31364	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 14 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $184.05 **Benefit:** 75% = $138.05 85% = $156.45
Amend Fee 31365	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372, 31373, 31377, 31378 or 31379), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is less than 15 mm; and

	(c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $173.35 **Benefit:** 75% = $130.05 85% = $147.35
Fee 31366	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $104.60 **Benefit:** 75% = $78.45 85% = $88.95
Amend Fee 31367	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $233.95 **Benefit:** 75% = $175.50 85% = $198.90
Fee 31368	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 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:** $137.50 **Benefit:** 75% = $103.15 85% = $116.90

Amend Fee 31369	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $269.35 **Benefit:** 75% = $202.05 85% = $228.95
Fee 31370	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.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $157.25 **Benefit:** 75% = $117.95 85% = $133.70
Fee 31371	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, including excision of the primary tumour bed, 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.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $391.00 **Benefit:** 75% = $293.25 85% = $332.35
Fee 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, including excision of the primary tumour bed, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 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 a service to which item 45201 applies (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $338.10 **Benefit:** 75% = $253.60 85% = $287.40
Fee 31373	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, including excision of the primary tumour bed, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $390.80 **Benefit:** 75% = $293.10 85% = $332.20
Fee 31374	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, including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.125, TN.8.22 of explanatory notes to this Category) **Fee:** $308.75 **Benefit:** 75% = $231.60 85% = $262.45
Fee 31375	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, including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $332.25 **Benefit:** 75% = $249.20 85% = $282.45

	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, including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is 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.)
Fee 31376	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $385.10 **Benefit:** 75% = $288.85 85% = $327.35
	Clinically suspected melanoma, surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6 mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.)
Fee 31377	(See para TN.8.125 of explanatory notes to this Category) **Fee:** $120.10 **Benefit:** 75% = $90.10 85% = $102.10
	Clinically suspected melanoma, surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.)
Fee 31378	(See para TN.8.125 of explanatory notes to this Category) **Fee:** $184.05 **Benefit:** 75% = $138.05 85% = $156.45
	Clinically suspected melanoma, 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 a service to which item 45201 applies (Anaes.)
Fee 31379	(See para TN.8.125 of explanatory notes to this Category) **Fee:** $146.70 **Benefit:** 75% = $110.05 85% = $124.70
Fee 31380	Clinically suspected melanoma, 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 (Anaes.) (See para TN.8.125 of explanatory notes to this Category) **Fee:** $184.05 **Benefit:** 75% = $138.05 85% = $156.45
Fee 31381	Clinically suspected melanoma, 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 31377, 31378, 31379 or 31380; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.125 of explanatory notes to this Category) **Fee:** $104.60 **Benefit:** 75% = $78.45 85% = $88.95
Fee 31382	Clinically suspected melanoma, 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 31377, 31378, 31379 or 31380; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.125 of explanatory notes to this Category) **Fee:** $137.50 **Benefit:** 75% = $103.15 85% = $116.90
Fee 31383	Clinically suspected melanoma, 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 31377, 31378, 31379 or 31380; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.125 of explanatory notes to this Category) **Fee:** $157.25 **Benefit:** 75% = $117.95 85% = $133.70
New 31386	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from the head or neck; and (b) the necessary excision diameter is more than 50 mm; and (c) the excision involves at least 2 critical areas (eyelid, nose, ear, mouth); and (d) the excised specimen is sent for histological examination; and

	(e) malignancy is confirmed from the excised specimen or previous biopsy; and (f) the service is not covered by item 31387 (Anaes.) (Assist.) (See para TN.8.272, TN.8.125, TN.8.22 of explanatory notes to this Category) **Fee:** $782.55 **Benefit:** 75% = $586.95 85% = $689.35
New 31387	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from the head or neck; and (b) the necessary excision diameter is more than 70 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; and (e) the service is not covered by item 31386 (Anaes.) (Assist.) (See para TN.8.272, TN.8.125, TN.8.22 of explanatory notes to this Category) **Fee:** $704.20 **Benefit:** 75% = $528.15 85% = $611.00
New 31388	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from the trunk or limbs; and (b) the necessary excision diameter is more than 120 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (Assist.) (See para TN.8.272, TN.8.125, TN.8.22 of explanatory notes to this Category) **Fee:** $633.75 **Benefit:** 75% = $475.35 85% = $540.55
Fee 31400	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $285.95 **Benefit:** 75% = $214.50 85% = $243.10
Fee 31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and including 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $330.00 **Benefit:** 75% = $247.50
Fee 31406	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $549.95 **Benefit:** 75% = $412.50 85% = $467.50
Fee 31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,708.75 **Benefit:** 75% = $1281.60
Fee 31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)

	Fee: $2,104.80 **Benefit:** 75% = $1578.60
Fee 31423	Lymph nodes of neck, selective dissection of one or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a patient 10 years of age or over, other than a service associated with a service to which item 30256 or 30275 applies on the same side (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $440.05 **Benefit:** 75% = $330.05 85% = $374.05
Fee 31426	Lymph nodes of neck, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $880.00 **Benefit:** 75% = $660.00
Fee 31429	Lymph nodes of neck, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,371.35 **Benefit:** 75% = $1028.55
Fee 31432	Lymph nodes of neck, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections), other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,466.70 **Benefit:** 75% = $1100.05
Fee 31435	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,078.05 **Benefit:** 75% = $808.55
Fee 31438	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,708.75 **Benefit:** 75% = $1281.60
Fee 31454	Laparoscopy or laparotomy with drainage of bile, as an independent procedure (H) (Anaes.) (Assist.) **Fee:** $617.00 **Benefit:** 75% = $462.75
Fee 31456	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.) **Fee:** $269.00 **Benefit:** 75% = $201.75
Fee 31458	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.) **Fee:** $322.70 **Benefit:** 75% = $242.05

Fee 31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.) **Fee:** $391.00 **Benefit:** 75% = $293.25
Fee 31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 31466	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $1,431.40 **Benefit:** 75% = $1073.55
Fee 31468	Para-oesophageal hiatus hernia, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication, other than a service associated with a service to which item 30756 or 31466 applies (Anaes.) (Assist.) **Fee:** $1,572.60 **Benefit:** 75% = $1179.45
Fee 31472	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-y loop to provide biliary drainage or bypass, other than a service associated with a service to which item 30584 applies (Anaes.) (Assist.) **Fee:** $1,473.40 **Benefit:** 75% = $1105.05
Fee 31500	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.) (See para TN.8.25 of explanatory notes to this Category) **Fee:** $284.80 **Benefit:** 75% = $213.60 85% = $242.10
Fee 31503	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.) (See para TN.8.25 of explanatory notes to this Category) **Fee:** $379.75 **Benefit:** 75% = $284.85 85% = $322.80
Fee 31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.) (See para TN.8.25 of explanatory notes to this Category) **Fee:** $427.25 **Benefit:** 75% = $320.45
Fee 31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.) (See para TN.8.25 of explanatory notes to this Category) **Fee:** $379.75 **Benefit:** 75% = $284.85 85% = $322.80
Amend Fee 31512	Breast, malignant tumour, complete local excision of, with or without frozen section histology, other than a service associated with a service to which: (a) item 45523 or 45558 applies; and (b) item 31513, 31514, 45520, 45522 or 45556 applies on the same side (if performed by the same medical practitioner) (H) (Anaes.) (Assist.) **Fee:** $712.05 **Benefit:** 75% = $534.05

New 31513	Breast, malignant tumour, complete local excision of, with simultaneous reshaping of the breast parenchyma using techniques such as round block or rotation flaps, other than a service associated with a service to which: (a) item 45523 or 45558 applies; and (b) item 31512, 31514, 45520, 45522 or 45556 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.265 of explanatory notes to this Category) **Fee:** $930.95 **Benefit:** 75% = $698.25
New 31514	Breast, malignant tumour, complete local excision of, with simultaneous ipsilateral pedicled breast reduction, including repositioning of the nipple, other than a service associated with a service to which: (a) item 45523 or 45558 applies; and (b) item 31512, 31513, 45520, 45522 or 45556 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.265 of explanatory notes to this Category) **Fee:** $1,342.20 **Benefit:** 75% = $1006.65
Fee 31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.) (See para TN.8.25 of explanatory notes to this Category) **Fee:** $477.70 **Benefit:** 75% = $358.30
Fee 31516	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology when targeted intraoperative radiation therapy (using an Intrabeam® or Xoft® Axxent® device) is performed concurrently, if the patient satisfies the requirements mentioned in paragraphs (a) to (g) of item 15900 Applicable only once per breast per lifetime (H) (Anaes.) (Assist.) **Fee:** $949.55 **Benefit:** 75% = $712.20
Amend Fee 31519	Total mastectomy (unilateral) (H) (Anaes.) (Assist.) **Fee:** $806.15 **Benefit:** 75% = $604.65
New 31520	Total mastectomy (bilateral) (H) (Anaes.) (Assist.) **Fee:** $1,410.75 **Benefit:** 75% = $1058.10
New 31522	Skin sparing mastectomy (unilateral) (H) (Anaes.) (Assist.) **Fee:** $1,139.30 **Benefit:** 75% = $854.50
New 31523	Skin sparing mastectomy (bilateral) (H) (Anaes.) (Assist.) **Fee:** $1,993.85 **Benefit:** 75% = $1495.40
Amend Fee 31525	Mastectomy for gynaecomastia (unilateral), with or without liposuction (suction assisted lipolysis), if: (a) breast enlargement is not due to obesity and is not proportionate to body habitus; and (b) sufficient photographic evidence demonstrating the clinical need for the service is included in

	patient notes; not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.) **Fee:** $569.50 **Benefit:** 75% = $427.15
New 31526	Mastectomy for gynaecomastia (bilateral), with or without liposuction (suction assisted lipolysis), if: (a) breast enlargement is not due to obesity and is not proportionate to body habitus; and (b) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes; not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.) **Fee:** $996.65 **Benefit:** 75% = $747.50
New 31528	Nipple sparing mastectomy (unilateral) (H) (Anaes.) (Assist.) **Fee:** $1,139.30 **Benefit:** 75% = $854.50
New 31529	Nipple sparing mastectomy (bilateral) (H) (Anaes.) (Assist.) **Fee:** $1,993.85 **Benefit:** 75% = $1495.40
Fee 31530	Breast, biopsy of solid tumour or tissue of, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, if imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than one cm in diameter; including pre-operative localisation of lesion, if performed, other than a service associated with a service to which item 31548 applies **Fee:** $652.40 **Benefit:** 75% = $489.30 85% = $559.20
Fee 31533	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.) (See para TN.8.26 of explanatory notes to this Category) **Fee:** $151.05 **Benefit:** 75% = $113.30 85% = $128.40
Fee 31536	Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques, but not including imaging (Anaes.) (Anaes.) **Fee:** $207.45 **Benefit:** 75% = $155.60 85% = $176.35
Fee 31548	Breast, biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination, other than a service associated with a service to which item 31530 applies (Anaes.) (Anaes.) (See para TN.8.26 of explanatory notes to this Category) **Fee:** $219.05 **Benefit:** 75% = $164.30 85% = $186.20
Fee 31551	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating theatre of a hospital, excluding aftercare (Anaes.) **Fee:** $237.35 **Benefit:** 75% = $178.05
Fee 31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.) **Fee:** $474.75 **Benefit:** 75% = $356.10
Fee 31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.) **Fee:** $379.75 **Benefit:** 75% = $284.85 85% = $322.80

Fee 31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.) **Fee:** $379.75 **Benefit:** 75% = $284.85 85% = $322.80 **Extended Medicare Safety Net Cap:** $303.80
Amend Fee 31563	Inverted nipple, surgical eversion of, with or without flap repair, if the nipple cannot readily be everted manually (Anaes.) **Fee:** $284.45 **Benefit:** 75% = $213.35 85% = $241.80
Fee 31566	ACCESSORY NIPPLE, excision of (Anaes.) **Fee:** $142.35 **Benefit:** 75% = $106.80 85% = $121.00
Fee 31585	Removal of adjustable gastric band (Anaes.) (Assist.) **Fee:** $911.35 **Benefit:** 75% = $683.55
	BARIATRIC
Fee 31569	Adjustable gastric band, placement of, 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:** $930.50 **Benefit:** 75% = $697.90
Fee 31572	Gastric bypass by Roux-en-Y including associated anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity not being associated with a service to which item 30515 applies (Anaes.) (Assist.) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $1,145.00 **Benefit:** 75% = $858.75
Fee 31575	Sleeve gastrectomy, 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:** $930.50 **Benefit:** 75% = $697.90
Fee 31578	Gastroplasty (excluding by gastric plication), 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:** $930.50 **Benefit:** 75% = $697.90
Fee 31581	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:** $1,145.00 **Benefit:** 75% = $858.75
Fee 31584	Surgical reversal of previous bariatric procedure, including revision or conversion, if: a) the previous procedure involved any of the following: (i) placement of adjustable gastric banding; (ii) gastric bypass; (iii) sleeve gastrectomy; (iv) gastroplasty (excluding gastric plication); (v) biliopancreatic diversion; and (b) any of items 31569 to 31581 applied to the previous procedure other than a service associated with a service to which item 31585 applies (Anaes.) (Assist.)

T8. SURGICAL OPERATIONS	1. GENERAL
	(See para TN.8.30 of explanatory notes to this Category) **Fee:** $1,685.70 **Benefit:** 75% = $1264.30
Fee 31587	Adjustment of gastric band as an independent procedure including any associated consultation **Fee:** $107.30 **Benefit:** 75% = $80.50 85% = $91.25
Fee 31590	Adjustment of gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.) **Fee:** $275.75 **Benefit:** 75% = $206.85 85% = $234.40

T8. SURGICAL OPERATIONS	2. COLORECTAL
	Group T8. Surgical Operations
	Subgroup 2. Colorectal
Fee 32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,129.50 **Benefit:** 75% = $847.15
Fee 32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.) **Fee:** $1,181.50 **Benefit:** 75% = $886.15
Fee 32004	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005, 32006 or 32030 applies (H) (Anaes.) (Assist.) **Fee:** $1,259.95 **Benefit:** 75% = $945.00
Fee 32005	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004, 32006 or 32030 applies (H) (Anaes.) (Assist.) **Fee:** $1,423.30 **Benefit:** 75% = $1067.50
Fee 32006	Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma), other than a service associated with a service to which item 32024, 32025, 32026 or 32028 applies (H) (Anaes.) (Assist.) **Fee:** $1,259.95 **Benefit:** 75% = $945.00
Fee 32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.) **Fee:** $1,494.55 **Benefit:** 75% = $1120.95
Fee 32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) **Fee:** $1,650.90 **Benefit:** 75% = $1238.20
Fee 32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.) **Fee:** $2,028.95 **Benefit:** 75% = $1521.75
Fee 32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) **Fee:** $1,720.50 **Benefit:** 75% = $1290.40

Fee 32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) **Fee:** $617.00 **Benefit:** 75% = $462.75
Fee 32023	Endoscopic insertion of stent or stents for large bowel obstruction, stricture or stenosis, including colonoscopy and any image intensification, where the obstruction is due to: a) a pre-diagnosed colorectal cancer, or cancer of an organ adjacent to the bowel; or b) an unknown diagnosis (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $608.25 **Benefit:** 75% = $456.20
Fee 32024	RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32000, 32030, 32106 or 32232 applies (H) (Anaes.) (Assist.) **Fee:** $1,494.55 **Benefit:** 75% = $1120.95
Fee 32025	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma not being a service associated with a service to which item 32000, 32030, 32106 or 32232 applies (H) (Anaes.) (Assist.) (See para TN.8.246 of explanatory notes to this Category) **Fee:** $1,999.10 **Benefit:** 75% = $1499.35
Fee 32026	Rectum, ultra-low restorative resection, with or without covering stoma and with or without colonic reservoir, if the anastomosis is sited in the anorectal region and is 6 cm or less from the anal verge, not being a service associated with a service to which item 32000, 32030, 32106, 32117 or 32232 applies (H) (Anaes.) (Assist.) (See para TN.8.246 of explanatory notes to this Category) **Fee:** $2,238.45 **Benefit:** 75% = $1678.85
Fee 32028	Rectum, low or ultra-low restorative resection, with per anal sutured coloanal anastomosis, with or without covering stoma and with or without colonic reservoir, not being a service associated with a service to which item 32000, 32030, 32106, 32117 or 32232 applies (H) (Anaes.) (Assist.) (See para TN.8.246 of explanatory notes to this Category) **Fee:** $2,377.80 **Benefit:** 75% = $1783.35
Fee 32030	RECTOSIGMOIDECTOMY, including formation of stoma (H) (Anaes.) (Assist.) **Fee:** $1,129.50 **Benefit:** 75% = $847.15
Fee 32033	RESTORATION OF BOWEL continuity following rectosigmoidectomy or similar operation, including dismantling of the stoma (H) (Anaes.) (Assist.) **Fee:** $1,650.90 **Benefit:** 75% = $1238.20
Fee 32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) **Fee:** $2,093.90 **Benefit:** 75% = $1570.45
Fee 32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.) **Fee:** $1,681.20 **Benefit:** 75% = $1260.90

Fee 32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) **Fee:** $1,416.30 **Benefit:** 75% = $1062.25
Fee 32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) **Fee:** $530.05 **Benefit:** 75% = $397.55
Fee 32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.) **Fee:** $819.10 **Benefit:** 75% = $614.35
Fee 32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.) **Fee:** $954.30 **Benefit:** 75% = $715.75
Fee 32051	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.) **Fee:** $2,537.15 **Benefit:** 75% = $1902.90
Fee 32054	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $2,328.65 **Benefit:** 75% = $1746.50
Fee 32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) **Fee:** $617.00 **Benefit:** 75% = $462.75
Fee 32060	Restorative proctectomy, involving rectal resection with formation of ileal reservoir and ileoanal anastomosis, including ileostomy mobilisation, with or without mucosectomy or temporary loop ileostomy, 1 surgeon (H) (Anaes.) (Assist.) **Fee:** $2,537.15 **Benefit:** 75% = $1902.90
Fee 32063	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $2,328.65 **Benefit:** 75% = $1746.50
Fee 32066	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.) **Fee:** $617.00 **Benefit:** 75% = $462.75
Fee 32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) **Fee:** $1,876.80 **Benefit:** 75% = $1407.60
Fee 32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy **Fee:** $52.40 **Benefit:** 75% = $39.30 85% = $44.55

Fee 32075	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL ANAESTHESIA, with or without biopsy, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $82.20 **Benefit:** 75% = $61.65 85% = $69.90
Fee 32084	Sigmoidoscopy or colonoscopy up to the hepatic flexure, with or without biopsy, other than a service associated with a service to which any of items 32222 to 32228 applies. (Anaes.) (See para TN.8.17, TN.8.134 of explanatory notes to this Category) **Fee:** $122.00 **Benefit:** 75% = $91.50 85% = $103.70
Fee 32087	Endoscopic examination of the colon up to the hepatic flexure by sigmoidoscopy or colonoscopy for the removal of one or more polyps, other than a service associated with a service to which any of items 32222 to 32228 applies (Anaes.) (Anaes.) (See para TN.8.17, TN.8.134 of explanatory notes to this Category) **Fee:** $224.20 **Benefit:** 75% = $168.15 85% = $190.60
Fee 32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $604.40 **Benefit:** 75% = $453.30
Fee 32095	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $140.00 **Benefit:** 75% = $105.00 85% = $119.00
Fee 32096	RECTAL BIOPSY, full thickness, to diagnose or exclude Hirschsprung's Disease, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.) **Fee:** $281.45 **Benefit:** 75% = $211.10
Fee 32105	ANORECTAL CARCINOMA per anal full thickness excision of (Anaes.) (Assist.) **Fee:** $530.05 **Benefit:** 75% = $397.55 85% = $450.55
Fee 32106	Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy digital viewing system and pneumorectum, if: (a) clinically appropriate; and (b) removal requires dissection within the peritoneal cavity; excluding use of a colonoscope as the operating platform and not being a service associated with a service to which item 32024, 32025 or 32232 applies (Anaes.) (Assist.) (See para TN.8.31, TN.8.17 of explanatory notes to this Category) **Fee:** $1,494.55 **Benefit:** 75% = $1120.95 85% = $1401.35
Fee 32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.) **Fee:** $1,094.90 **Benefit:** 75% = $821.20

Fee 32117	Rectal prolapse, abdominal rectopexy of, excluding ventral mesh rectopexy, not being a service associated with a service to which item 32025 or 32026 applies (H) (Anaes.) (Assist.) **Fee:** $1,375.80 **Benefit:** 75% = $1031.85
Fee 32118	Rectal prolapse, ventral mesh rectopexy of, not being a service associated with a service to which item 32025, 32026 or 32117 applies (H) (Anaes.) (Assist.) **Fee:** $1,375.80 **Benefit:** 75% = $1031.85
Fee 32123	ANAL STRICTURE, anoplasty for (Anaes.) (Assist.) **Fee:** $365.00 **Benefit:** 75% = $273.75 85% = $310.25
Fee 32129	ANAL SPHINCTER, repair (H) (Anaes.) (Assist.) **Fee:** $695.10 **Benefit:** 75% = $521.35
Fee 32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.) **Fee:** $584.45 **Benefit:** 75% = $438.35
Fee 32135	Treatment of haemorrhoids or rectal prolapse, including rubber band ligation or sclerotherapy for, not being a service to which item 32139 applies (Anaes.) **Fee:** $73.95 **Benefit:** 75% = $55.50 85% = $62.90
Fee 32139	Operative treatment of haemorrhoids involving third-degree or fourth-degree haemorrhoids, including excision of anal skin tags when performed, not being a service associated with a service to which item 32135 or 32233 applies (H) (Anaes.) (Assist.) **Fee:** $402.75 **Benefit:** 75% = $302.10
Fee 32147	PERIANAL THROMBOSIS, incision of (Anaes.) **Fee:** $49.35 **Benefit:** 75% = $37.05 85% = $41.95
Fee 32150	Operation for anal fissure, including excision, injection of Botulinum toxin or sphincterotomy, excluding dilatation (Anaes.) (Assist.) **Fee:** $281.45 **Benefit:** 75% = $211.10 85% = $239.25
Fee 32156	Anal fistula, subcutaneous, excision of (Anaes.) **Fee:** $144.25 **Benefit:** 75% = $108.20 85% = $122.65
Fee 32159	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (Anaes.) (Assist.) **Fee:** $365.00 **Benefit:** 75% = $273.75
Fee 32162	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Anaes.) (Assist.) **Fee:** $530.05 **Benefit:** 75% = $397.55
Fee 32165	Operative treatment of anal fistula, repair by mucosal advancement flap, including ligation of inter-sphincteric fistula tract (LIFT) or other complex sphincter sparing surgery (Anaes.) (Assist.) **Fee:** $695.10 **Benefit:** 75% = $521.35 85% = $601.90
Fee 32166	ANAL FISTULA - readjustment of Seton (Anaes.) **Fee:** $225.85 **Benefit:** 75% = $169.40 85% = $192.00

Fee 32171	Anorectal examination, with or without biopsy, under general anaesthetic, with or without faecal disimpaction, other than a service associated with a service to which another item in this Group applies (H) (Anaes.) **Fee:** $97.25 **Benefit:** 75% = $72.95
Fee 32174	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
Fee 32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.) **Fee:** $178.15 **Benefit:** 75% = $133.65
Fee 32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) **Fee:** $615.10 **Benefit:** 75% = $461.35
Fee 32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) **Fee:** $615.10 **Benefit:** 75% = $461.35
Fee 32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.) **Fee:** $149.25 **Benefit:** 75% = $111.95
Fee 32213	Sacral nerve lead or leads, placement of, percutaneous or open, including intraoperative test stimulation and programming, for the management of faecal incontinence (H) (Anaes.) (See para TN.8.247 of explanatory notes to this Category) **Fee:** $723.90 **Benefit:** 75% = $542.95
Fee 32215	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, not being a service associated with a service to which item 32213, 32216, 32218 or 32237 applies. Applicable once per day for the same patient by the same practitioner **Fee:** $137.30 **Benefit:** 75% = $103.00 85% = $116.75
Fee 32216	Sacral nerve lead or leads, inserted for the management of faecal incontinence in a patient with faecal incontinence refractory to conservative non-surgical treatment, either: (a) percutaneous surgical repositioning of the lead or leads, using fluoroscopic guidance; or (b) open surgical repositioning of the lead or leads; to correct displacement or unsatisfactory positioning (including intraoperative test stimulation), not being a service associated with a service to which item 32213 applies (H) (Anaes.) (See para TN.8.247 of explanatory notes to this Category) **Fee:** $650.10 **Benefit:** 75% = $487.60
Fee 32218	Sacral nerve lead or leads, removal (H) (Anaes.) **Fee:** $171.20 **Benefit:** 75% = $128.40
Amend Fee 32221	Removal or revision of an artificial bowel sphincter (with or without replacement) for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. (Anaes.) (Assist.) (See para TN.8.277 of explanatory notes to this Category)

	Fee: $990.00 **Benefit:** 75% = $742.50 85% = $896.80
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) following a positive faecal occult blood test; or (b) who has symptoms consistent with pathology of the colonic mucosa; or (c) with anaemia or iron deficiency; or (d) for whom diagnostic imaging has shown an abnormality of the colon; or (e) who is undergoing the first examination following surgery for colorectal cancer; or (f) who is undergoing pre-operative evaluation; or (g) for whom a repeat colonoscopy is required due to inadequate bowel preparation for the patient's previous colonoscopy; or (h) for the management of inflammatory bowel disease Applicable only once on a day under a single episode of anaesthesia or other sedation (Anaes.)
Fee 32222	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) **Fee:** $366.15 **Benefit:** 75% = $274.65 85% = $311.25
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) who has had a colonoscopy that revealed: (i) 1 to 4 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or (ii) 1 or 2 sessile serrated lesions, each of which was less than 10 mm in diameter, and without dysplasia; or (b) with a moderate risk of colorectal cancer due to family history; or (c) with a history of colorectal cancer, who has had an initial post-operative colonoscopy that did not reveal any adenomas or colorectal cancer Applicable only once in any 5 year period.
Fee 32223	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) **Fee:** $366.15 **Benefit:** 75% = $274.65 85% = $311.25
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a moderate risk of colorectal cancer due to: (a) a history of adenomas, including an adenoma that: (i) was 10 mm or greater in diameter; or (ii) had villous features; or (iii) had high grade dysplasia; or
Fee 32224	(b) having had a previous colonoscopy that revealed:

	(i) 5 to 9 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or (ii) 1 or 2 sessile serrated lesions, each of which was 10 mm or greater in diameter or had dysplasia; or (iii) a hyperplastic polyp that was 10 mm or greater in diameter; or (iv) 3 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (v) 1 or 2 traditional serrated adenomas, of any size Applicable only once in any 3 year period (Anaes.) (See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) **Fee:** $366.15 **Benefit:** 75% = $274.65 85% = $311.25
Fee 32225	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a high risk of colorectal cancer due to having had a previous colonoscopy that: (a) revealed 10 or more adenomas; or (b) included a piecemeal, or possibly incomplete, excision of a large, sessile polyp Applicable not more than 4 times in any 12 month period (Anaes.) (See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) **Fee:** $366.15 **Benefit:** 75% = $274.65 85% = $311.25
Fee 32226	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk of colorectal cancer due to: (a) having either: (i) a known or suspected familial condition, such as familial adenomatous polyposis, Lynch syndrome or serrated polyposis syndrome; or (ii) a genetic mutation associated with hereditary colorectal cancer; or (b) having had a previous colonoscopy that revealed: (i) 5 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (ii) 3 or more sessile serrated lesions, 1 or more of which was 10 mm or greater in diameter or had dysplasia; or (iii) 3 or more traditional serrated adenomas, of any size Applicable only once in any 12 month period (Anaes.) (See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) **Fee:** $366.15 **Benefit:** 75% = $274.65 85% = $311.25
Fee 32227	Endoscopic examination of the colon to the caecum by colonoscopy: (a) for the treatment of bleeding, including one or more of the following:

	(i) radiation proctitis; (ii) angioectasia; (iii) post-polypectomy bleeding; or (b) for the treatment of colonic strictures with balloon dilatation Applicable only once on a day under a single episode of anaesthesia or other sedation (Anaes.) (See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) **Fee:** $513.85 **Benefit:** 75% = $385.40 85% = $436.80
Fee 32228	Endoscopic examination of the colon to the caecum by colonoscopy, other that a service to which item 32222, 32223, 32224, 32225, or 32226 applies. Applicable only once (Anaes.) (See para TN.8.17, TN.8.2, TN.8.152 of explanatory notes to this Category) **Fee:** $366.15 **Benefit:** 75% = $274.65 85% = $311.25
Fee 32229	Removal of one or more polyps during colonoscopy, in association with a service to which item 32222, 32223, 32224, 32225, 32226, or 32228 applies (Anaes.) (See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) **Fee:** $295.35 **Benefit:** 75% = $221.55 85% = $251.05
Fee 32230	Endoscopic mucosal resection using electrocautery of a non-invasive sessile or flat superficial colorectal neoplasm which is at least 25mm in diameter, if the service is: (a) provided by a specialist gastroenterologist or surgical endoscopist; and (b) supported by photographic evidence to confirm the size of the polyp in situ, and (c) performed within 6 months after a service to which item 32222, 32223, 32224, 32225, 32226 or 32228 applies has been performed Applicable only once per polyp (H) (Anaes.) **Fee:** $731.80 **Benefit:** 75% = $548.85
Fee 32231	Rectal tumour, per anal excision of (H) (Anaes.) (Assist.) **Fee:** $365.00 **Benefit:** 75% = $273.75
Fee 32232	Rectal tumour, per anal excision of, using a rectoscopy digital viewing system and pneumorectum if clinically appropriate and excluding use of a colonoscope as the operating platform, not being a service associated with a service to which item 32024, 32025 or 32106 applies (H) (Anaes.) (Assist.) (See para TN.8.31, TN.8.17 of explanatory notes to this Category) **Fee:** $989.55 **Benefit:** 75% = $742.20
Fee 32233	Perineal repair of rectal prolapse, not being a service associated with a service to which item 32139 applies (H) (Anaes.) (Assist.) **Fee:** $702.80 **Benefit:** 75% = $527.10
Fee 32234	Rectal stricture, treatment of (H) (Anaes.) **Fee:** $139.00 **Benefit:** 75% = $104.25

T8. SURGICAL OPERATIONS	2. COLORECTAL
Fee 32235	Anal skin tags or anal polyps, excision of one or more of (Anaes.) **Fee:** $134.15 **Benefit:** 75% = $100.65 85% = $114.05
Fee 32236	Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block), not being a service associated with a service to which item 35507 or 35508 applies (H) (Anaes.) **Fee:** $190.85 **Benefit:** 75% = $143.15
Fee 32237	Neurostimulator or receiver, subcutaneous placement of, replacement of, or removal of, including programming and placement and connection of an extension wire or wires to sacral nerve electrode(s), for the management of faecal incontinence (H) (Anaes.) (Assist.) **Fee:** $309.50 **Benefit:** 75% = $232.15

T8. SURGICAL OPERATIONS	3. VASCULAR
	Group T8. Surgical Operations
	Subgroup 3. Vascular
	VARICOSE VEINS
Fee 32500	Varicose veins, multiple injections of sclerosant using continuous compression techniques, including associated consultation, one or both legs, if: (a) proximal reflux of 0.5 seconds or longer has been demonstrated; and (b) the service is not for cosmetic purposes; and (c) the service is not associated with: (i) any other varicose vein operation on the same leg (excluding aftercare); or (ii) a service on the same leg (excluding aftercare) to which any of the following items apply: (A) 35200; (B) 59970 to 60078; (C) 60500 to 60509; (D) 61109 Applicable to a maximum of 6 treatments in a 12 month period (Anaes.) (See para TN.8.4, TN.8.32, TN.8.33, TN.8.228 of explanatory notes to this Category) **Fee:** $120.25 **Benefit:** 75% = $90.20 85% = $102.25 **Extended Medicare Safety Net Cap:** $132.30
Fee 32504	VARICOSE VEINS, multiple excision of tributaries, with or without division of 1 or more perforating veins - 1 leg - not being a service associated with a service to which item 32507, 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25

	Extended Medicare Safety Net Cap: $234.60
	Varicose veins, sub-fascial ligation of one or more incompetent perforating veins in one leg of a patient, if the service: (a) is performed by open surgical technique (not including endoscopic ligation) and the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; and (b) is not associated with: (i) any other varicose vein operation on the same leg; or (ii) a service (on the same leg) to which item 35200, 60072, 60075 or 60078 applies (H) (Anaes.) (Assist.) (See para TN.8.32, TN.8.33 of explanatory notes to this Category)
Fee 32507	**Fee:** $584.45 **Benefit:** 75% = $438.35 **Extended Medicare Safety Net Cap:** $467.60
	Varicose veins, complete dissection at the sapheno-femoral or sapheno-popliteal junction, with or without either ligation or stripping, or both, of the great or small saphenous veins in one leg of a patient, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness;
Fee 32508	

	(f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.) (See para TN.8.32, TN.8.33 of explanatory notes to this Category) **Fee:** $584.45 **Benefit:** 75% = $438.35
Fee 32511	Varicose veins, complete dissection at the sapheno-femoral and sapheno-popliteal junction, with or without either ligation or stripping, or both, of the great or small saphenous veins in one leg of a patient, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.) (See para TN.8.32, TN.8.33 of explanatory notes to this Category) **Fee:** $868.85 **Benefit:** 75% = $651.65
Fee 32514	Varicose veins, ligation of the great or small saphenous vein in the same leg of a patient, with or without stripping, by re-operation for recurrent veins in the same territory—one leg—including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness;

	(d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.) (See para TN.8.32, TN.8.33 of explanatory notes to this Category) **Fee:** $1,015.05 **Benefit:** 75% = $761.30
Fee 32517	Varicose veins, ligation of the great and small saphenous vein in the same leg of a patient, with or without stripping, by re-operation for recurrent veins in either territory—one leg—including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.) (See para TN.8.32, TN.8.33 of explanatory notes to this Category) **Fee:** $1,307.05 **Benefit:** 75% = $980.30
Fee 32520	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a laser probe introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) of the patient demonstrates reflux of 0.5 seconds or longer;

	(b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $584.45 **Benefit:** 75% = $438.35 85% = $496.80 **Extended Medicare Safety Net Cap:** $87.70
Fee 32522	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a laser probe introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins of the patient demonstrate reflux of 0.5 seconds or longer;

	(b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $868.85 **Benefit:** 75% = $651.65 85% = $775.65 **Extended Medicare Safety Net Cap:** $86.90
Fee 32523	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a radiofrequency catheter introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer;

	(b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include endovenous laser therapy or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $584.45 **Benefit:** 75% = $438.35 85% = $496.80 **Extended Medicare Safety Net Cap:** $87.70
Fee 32526	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a radiofrequency catheter introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer;

	(b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include endovenous laser therapy or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $868.85 **Benefit:** 75% = $651.65 85% = $775.65 **Extended Medicare Safety Net Cap:** $86.90
Fee 32528	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using cyanoacrylate adhesive, if all of the following apply: (a) it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer;

	(b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service include all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $584.45 **Benefit:** 75% = $438.35 85% = $496.80 **Extended Medicare Safety Net Cap:** $87.70
Fee 32529	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using cyanoacrylate adhesive, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer;

	(b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $868.85 **Benefit:** 75% = $651.65 85% = $775.65 **Extended Medicare Safety Net Cap:** $86.90
	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE
Fee 32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,573.10 **Benefit:** 75% = $1179.85
Fee 32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.)

	Fee: $1,301.35 **Benefit:** 75% = $976.05
Fee 32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) **Fee:** $1,556.70 **Benefit:** 75% = $1167.55
Fee 32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.) **Fee:** $1,729.65 **Benefit:** 75% = $1297.25
Fee 32711	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes.) (Assist.) **Fee:** $1,902.65 **Benefit:** 75% = $1427.00
Fee 32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,375.40 **Benefit:** 75% = $1031.55
Fee 32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) **Fee:** $1,375.40 **Benefit:** 75% = $1031.55
Fee 32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,301.35 **Benefit:** 75% = $976.05
Fee 32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) **Fee:** $2,067.05 **Benefit:** 75% = $1550.30
Fee 32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) **Fee:** $2,347.20 **Benefit:** 75% = $1760.40
Fee 32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,779.00 **Benefit:** 75% = $1334.25
Fee 32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.) **Fee:** $2,067.05 **Benefit:** 75% = $1550.30
Fee 32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) **Fee:** $452.95 **Benefit:** 75% = $339.75
Fee 32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.) (Assist.) **Fee:** $1,416.55 **Benefit:** 75% = $1062.45
Fee 32742	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.) **Fee:** $1,622.60 **Benefit:** 75% = $1216.95

Fee 32745	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Anaes.) (Assist.) **Fee:** $1,853.05 **Benefit:** 75% = $1389.80
Fee 32748	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.) **Fee:** $2,009.55 **Benefit:** 75% = $1507.20
Fee 32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.) **Fee:** $1,301.35 **Benefit:** 75% = $976.05
Fee 32754	FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes.) (Assist.) **Fee:** $1,622.60 **Benefit:** 75% = $1216.95
Fee 32757	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Anaes.) (Assist.) **Fee:** $452.95 **Benefit:** 75% = $339.75
Fee 32760	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes.) (Assist.) **Fee:** $444.70 **Benefit:** 75% = $333.55
Fee 32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,301.35 **Benefit:** 75% = $976.05
Fee 32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.) **Fee:** $864.90 **Benefit:** 75% = $648.70
Fee 32769	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.) (Assist.) **Fee:** $299.70 **Benefit:** 75% = $224.80
	BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS
Fee 33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.) **Fee:** $1,593.95 **Benefit:** 75% = $1195.50
Fee 33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.) **Fee:** $1,278.20 **Benefit:** 75% = $958.65

T8. SURGICAL OPERATIONS	3. VASCULAR
Fee 33070	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $922.15 **Benefit:** 75% = $691.65 85% = $828.95
Fee 33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,173.05 **Benefit:** 75% = $879.80
Fee 33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,431.95 **Benefit:** 75% = $1074.00
Fee 33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,573.10 **Benefit:** 75% = $1179.85 85% = $1479.90
Fee 33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,207.20 **Benefit:** 75% = $1655.40
Fee 33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $2,668.55 **Benefit:** 75% = $2001.45 85% = $2575.35
Fee 33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $2,314.30 **Benefit:** 75% = $1735.75
Fee 33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.) **Fee:** $1,556.70 **Benefit:** 75% = $1167.55
Fee 33116	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) **Fee:** $1,532.25 **Benefit:** 75% = $1149.20 85% = $1439.05
Fee 33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.) (Assist.) **Fee:** $1,729.65 **Benefit:** 75% = $1297.25
Fee 33119	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) **Fee:** $1,702.60 **Benefit:** 75% = $1276.95 85% = $1609.40
Fee 33121	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) **Fee:** $1,902.65 **Benefit:** 75% = $1427.00

Fee 33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.) **Fee:** $1,326.10 **Benefit:** 75% = $994.60
Fee 33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes.) (Assist.) **Fee:** $1,737.90 **Benefit:** 75% = $1303.45 85% = $1644.70
Fee 33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.) **Fee:** $1,515.45 **Benefit:** 75% = $1136.60
Fee 33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.) **Fee:** $1,136.50 **Benefit:** 75% = $852.40
Fee 33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) **Fee:** $2,865.95 **Benefit:** 75% = $2149.50
Fee 33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,737.90 **Benefit:** 75% = $1303.45
Fee 33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,622.60 **Benefit:** 75% = $1216.95 85% = $1529.40
Fee 33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,791.95 **Benefit:** 75% = $2094.00
Fee 33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,467.30 **Benefit:** 75% = $2600.50
Fee 33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,294.40 **Benefit:** 75% = $2470.80
Fee 33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) **Fee:** $2,437.80 **Benefit:** 75% = $1828.35
Fee 33157	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) **Fee:** $2,717.80 **Benefit:** 75% = $2038.35
Fee 33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) **Fee:** $2,717.80 **Benefit:** 75% = $2038.35

Fee 33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,306.25 **Benefit:** 75% = $1729.70
Fee 33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.) **Fee:** $2,306.25 **Benefit:** 75% = $1729.70 85% = $2213.05
Fee 33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) **Fee:** $1,795.50 **Benefit:** 75% = $1346.65
Fee 33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,400.10 **Benefit:** 75% = $1050.10
Fee 33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,290.30 **Benefit:** 75% = $967.75
Fee 33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,640.85 **Benefit:** 75% = $1230.65
Fee 33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $2,006.10 **Benefit:** 75% = $1504.60
	ENDARTERECTOMY AND ARTERIAL PATCH
Fee 33500	ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.) **Fee:** $1,243.50 **Benefit:** 75% = $932.65
Fee 33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $1,391.90 **Benefit:** 75% = $1043.95
Fee 33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.) **Fee:** $1,556.70 **Benefit:** 75% = $1167.55
Fee 33512	AORTO-ILIAC ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Anaes.) (Assist.) **Fee:** $1,729.65 **Benefit:** 75% = $1297.25
Fee 33515	AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes.) (Assist.) **Fee:** $1,902.65 **Benefit:** 75% = $1427.00
Fee 33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.)

	Fee: $1,391.90 **Benefit:** 75% = $1043.95 85% = $1298.70
Fee 33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.) **Fee:** $1,507.05 **Benefit:** 75% = $1130.30
Fee 33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,779.00 **Benefit:** 75% = $1334.25
Fee 33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.) **Fee:** $2,067.05 **Benefit:** 75% = $1550.30
Fee 33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,779.00 **Benefit:** 75% = $1334.25
Fee 33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $2,067.05 **Benefit:** 75% = $1550.30
Fee 33536	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,474.30 **Benefit:** 75% = $1105.75
Fee 33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $1,062.40 **Benefit:** 75% = $796.80
Fee 33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.) **Fee:** $1,515.45 **Benefit:** 75% = $1136.60
Fee 33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $299.70 **Benefit:** 75% = $224.80
Fee 33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $609.60 **Benefit:** 75% = $457.20
Fee 33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $299.70 **Benefit:** 75% = $224.80
Fee 33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.) **Fee:** $298.35 **Benefit:** 75% = $223.80
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA
Fee 33800	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.) **Fee:** $1,293.05 **Benefit:** 75% = $969.80 85% = $1199.85

T8. SURGICAL OPERATIONS	3. VASCULAR
Fee 33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.) **Fee:** $1,235.50 **Benefit:** 75% = $926.65
Fee 33806	Embolectomy or thrombectomy (including the infusion of thrombolytic or other agents) from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery, item to be claimed once per extremity, regardless of the number of incisions required to access the artery or bypass graft (Anaes.) (Assist.) **Fee:** $889.50 **Benefit:** 75% = $667.15 85% = $796.30
Fee 33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.) **Fee:** $648.90 **Benefit:** 75% = $486.70 85% = $555.70
Fee 33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.) **Fee:** $1,931.75 **Benefit:** 75% = $1448.85
Fee 33812	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.) **Fee:** $1,021.20 **Benefit:** 75% = $765.90 85% = $928.00
Fee 33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $938.85 **Benefit:** 75% = $704.15
Fee 33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,095.40 **Benefit:** 75% = $821.55
Fee 33821	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) **Fee:** $1,251.85 **Benefit:** 75% = $938.90
Fee 33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $1,194.15 **Benefit:** 75% = $895.65
Fee 33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,400.10 **Benefit:** 75% = $1050.10
Fee 33830	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) **Fee:** $1,605.90 **Benefit:** 75% = $1204.45
Fee 33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.) **Fee:** $1,457.90 **Benefit:** 75% = $1093.45
Fee 33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.)

	Fee: $1,737.90 **Benefit:** 75% = $1303.45
Fee 33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.) **Fee:** $2,034.25 **Benefit:** 75% = $1525.70
Fee 33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.) **Fee:** $1,004.75 **Benefit:** 75% = $753.60
Fee 33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $700.15 **Benefit:** 75% = $525.15
Fee 33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $700.15 **Benefit:** 75% = $525.15
	LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS
Fee 34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.) **Fee:** $774.25 **Benefit:** 75% = $580.70
Fee 34103	Great artery (aorta or pulmonary artery) or great vein (superior or inferior vena cava), ligation or exploration of immediate branches or tributaries, or ligation or exploration of the subclavian, axillary, iliac, femoral or popliteal arteries or veins, if the service is not associated with item 32508, 32511, 32520, 32522, 32523, 32526, 32528 or 32529 - for a maximum of 2 services provided to the same patient on the same occasion (H) (Anaes.) (Assist.) **Fee:** $452.95 **Benefit:** 75% = $339.75
Fee 34106	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.) **Fee:** $319.45 **Benefit:** 75% = $239.60 85% = $271.55 **Extended Medicare Safety Net Cap:** $255.60
Fee 34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) **Fee:** $370.60 **Benefit:** 75% = $277.95 85% = $315.05
Fee 34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) **Fee:** $938.85 **Benefit:** 75% = $704.15
Fee 34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) **Fee:** $1,062.40 **Benefit:** 75% = $796.80
Fee 34118	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.) **Fee:** $1,515.45 **Benefit:** 75% = $1136.60 85% = $1422.25
Fee 34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)

	Fee: $1,210.60 **Benefit:** 75% = $907.95
Fee 34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,326.10 **Benefit:** 75% = $994.60
Fee 34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,737.90 **Benefit:** 75% = $1303.45
Fee 34130	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.) **Fee:** $543.55 **Benefit:** 75% = $407.70 85% = $462.05
Fee 34133	SCALENOTOMY (Anaes.) (Assist.) **Fee:** $609.60 **Benefit:** 75% = $457.20
Fee 34136	FIRST RIB, resection of portion of (Anaes.) (Assist.) **Fee:** $979.95 **Benefit:** 75% = $735.00
Fee 34139	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $979.95 **Benefit:** 75% = $735.00
Fee 34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.) **Fee:** $1,210.60 **Benefit:** 75% = $907.95
Fee 34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) **Fee:** $881.20 **Benefit:** 75% = $660.90
Fee 34148	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.) **Fee:** $1,573.10 **Benefit:** 75% = $1179.85
Fee 34151	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.) **Fee:** $2,149.50 **Benefit:** 75% = $1612.15
Fee 34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.) **Fee:** $2,561.45 **Benefit:** 75% = $1921.10 85% = $2468.25
Fee 34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) **Fee:** $1,301.35 **Benefit:** 75% = $976.05
Fee 34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,437.80 **Benefit:** 75% = $1828.35

Fee 34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) **Fee:** $3,129.60 **Benefit:** 75% = $2347.20
Fee 34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) **Fee:** $3,129.60 **Benefit:** 75% = $2347.20
Fee 34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,737.90 **Benefit:** 75% = $1303.45
Fee 34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,416.55 **Benefit:** 75% = $1062.45
Fee 34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.) **Fee:** $1,301.35 **Benefit:** 75% = $976.05
	OPERATIONS FOR VASCULAR ACCESS
Fee 34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.) **Fee:** $337.80 **Benefit:** 75% = $253.35 85% = $287.15
Fee 34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $452.95 **Benefit:** 75% = $339.75
Fee 34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.) **Fee:** $230.45 **Benefit:** 75% = $172.85
Fee 34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $1,070.60 **Benefit:** 75% = $802.95
Fee 34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.) **Fee:** $1,177.85 **Benefit:** 75% = $883.40
Fee 34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.) **Fee:** $840.00 **Benefit:** 75% = $630.00
Fee 34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.) **Fee:** $1,408.20 **Benefit:** 75% = $1056.15
Fee 34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $865.20 **Benefit:** 75% = $648.90

Fee 34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $452.95 **Benefit:** 75% = $339.75
Fee 34527	CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation, on a patient 10 years of age or over (Anaes.) **Fee:** $604.15 **Benefit:** 75% = $453.15 85% = $513.55
Fee 34528	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a patient 10 years of age or over (Anaes.) **Fee:** $298.35 **Benefit:** 75% = $223.80 85% = $253.60
Fee 34529	CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation, on a patient under 10 years of age (Anaes.) **Fee:** $785.40 **Benefit:** 75% = $589.05 85% = $692.20
Fee 34530	CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital on a patient 10 years of age or over (Anaes.) **Fee:** $223.65 **Benefit:** 75% = $167.75 85% = $190.15
Fee 34533	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Anaes.) (Assist.) **Fee:** $1,358.75 **Benefit:** 75% = $1019.10 85% = $1265.55
Fee 34534	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a patient under 10 years of age (Anaes.) **Fee:** $387.85 **Benefit:** 75% = $290.90 85% = $329.70
Fee 34538	CENTRAL VEIN CATHERTERISATION by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.) **Fee:** $298.35 **Benefit:** 75% = $223.80 85% = $253.60
Fee 34539	TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical procedure (Anaes.) **Fee:** $223.65 **Benefit:** 75% = $167.75 85% = $190.15
Fee 34540	CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital, on a patient under 10 years of age (Anaes.) **Fee:** $290.75 **Benefit:** 75% = $218.10 85% = $247.15
	COMPLEX VENOUS OPERATIONS
Fee 34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) **Fee:** $889.50 **Benefit:** 75% = $667.15 85% = $796.30

Fee 34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,960.30 **Benefit:** 75% = $1470.25
Fee 34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) **Fee:** $1,062.40 **Benefit:** 75% = $796.80
Fee 34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) **Fee:** $1,062.40 **Benefit:** 75% = $796.80
Fee 34812	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.) **Fee:** $1,284.80 **Benefit:** 75% = $963.60
Fee 34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $1,062.40 **Benefit:** 75% = $796.80
Fee 34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) **Fee:** $1,169.50 **Benefit:** 75% = $877.15
Fee 34821	VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.) **Fee:** $1,589.60 **Benefit:** 75% = $1192.20 85% = $1496.40
Fee 34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.) **Fee:** $543.55 **Benefit:** 75% = $407.70
Fee 34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.) **Fee:** $658.95 **Benefit:** 75% = $494.25
Fee 34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.) **Fee:** $774.25 **Benefit:** 75% = $580.70 85% = $681.05
Fee 34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) **Fee:** $1,004.75 **Benefit:** 75% = $753.60
	SYMPATHECTOMY
Fee 35000	LUMBAR SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $774.25 **Benefit:** 75% = $580.70 85% = $681.05
Fee 35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) **Fee:** $1,004.75 **Benefit:** 75% = $753.60

Fee 35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) **Fee:** $1,260.15 **Benefit:** 75% = $945.15
Fee 35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) **Fee:** $979.95 **Benefit:** 75% = $735.00
Fee 35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $774.25 **Benefit:** 75% = $580.70
	DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
Fee 35100	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Anaes.) (Assist.) **Fee:** $403.65 **Benefit:** 75% = $302.75
Fee 35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) **Fee:** $256.90 **Benefit:** 75% = $192.70
	MISCELLANEOUS VASCULAR PROCEDURES
Fee 35200	OPERATIVE ARTERIOGRAPHY OR VENOGRAPHY, 1 or more of, performed during the course of an operative procedure on an artery or vein, 1 site (Anaes.) **Fee:** $187.85 **Benefit:** 75% = $140.90
Fee 35202	MAJOR ARTERIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of RE-OPERATION after prior surgery on these vessels (Anaes.) (Assist.) **Fee:** $894.90 **Benefit:** 75% = $671.20
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
Fee 35300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $564.45 **Benefit:** 75% = $423.35 85% = $479.80
Fee 35303	TRANSLUMINAL BALLOON ANGIOPLASTY of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $723.70 **Benefit:** 75% = $542.80 85% = $630.50
Fee 35306	TRANSLUMINAL STENT INSERTION, 1 or more stents, including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare. (Anaes.) (Assist.) **Fee:** $667.95 **Benefit:** 75% = $501.00 85% = $574.75
Fee 35307	TRANSLUMINAL STENT INSERTION, 1 or more stents (not drug-eluting), with or without associated balloon dilatation, for 1 carotid artery, percutaneous (not direct), with or without the use of an embolic protection device, in patients who: - meet the indications for carotid endarterectomy; and

	- have medical or surgical comorbidities that would make them at high risk of perioperative complications from carotid endarterectomy, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.37 of explanatory notes to this Category) **Fee:** $1,227.90 **Benefit:** 75% = $920.95
Fee 35309	TRANSLUMINAL STENT INSERTION, 1 or more stents, including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare. (Anaes.) (Assist.) **Fee:** $834.95 **Benefit:** 75% = $626.25 85% = $741.75
Fee 35312	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $946.30 **Benefit:** 75% = $709.75
Fee 35315	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $946.30 **Benefit:** 75% = $709.75
Fee 35317	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) (See para TN.8.38 of explanatory notes to this Category) **Fee:** $389.65 **Benefit:** 75% = $292.25 85% = $331.25
Fee 35319	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) **Fee:** $698.45 **Benefit:** 75% = $523.85 85% = $605.25
Fee 35320	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) **Fee:** $938.25 **Benefit:** 75% = $703.70 85% = $845.05
Fee 35321	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for the treatment of uterine fibroids or varicose veins) percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category)

	Fee: $890.75 **Benefit:** 75% = $668.10 85% = $797.55
Fee 35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $334.05 **Benefit:** 75% = $250.55
Fee 35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $447.65 **Benefit:** 75% = $335.75
Fee 35330	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $564.45 **Benefit:** 75% = $423.35 85% = $479.80
Fee 35331	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.) **Fee:** $648.90 **Benefit:** 75% = $486.70
Fee 35360	Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(foreign body does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $907.05 **Benefit:** 75% = $680.30
Fee 35361	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(foreign body does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $777.90 **Benefit:** 75% = $583.45
Fee 35362	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(foreign body does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $648.90 **Benefit:** 75% = $486.70
Fee 35363	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(foreign body does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.)

	Fee: $519.85 **Benefit:** 75% = $389.90
	INTERVENTIONAL RADIOLOGY PROCEDURES
Fee 35401 S	Vertebroplasty, for one or more fractures in one or more vertebrae, performed by an interventional radiologist, for the treatment of a painful osteoporotic thoracolumbar vertebral compression fracture of the thoracolumbar spinal segment (T11, T12, L1 or L2), if: (a) pain is severe (numeric rated pain score greater than or equal to 7 out of 10); and (b) symptoms are poorly controlled by opiate therapy; and (c) severe pain duration is 3 weeks or less; and (d) there is MRI (or SPECT-CT if MRI unavailable) evidence of acute vertebral fracture Applicable only once for the same fracture, but is applicable for a new fracture of the same vertebra or vertebrae (H) (Anaes.) **Fee:** $747.85 **Benefit:** 75% = $560.90
Fee 35404	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective internal radiation therapy of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies The procedure must be performed by a specialist or consultant physician recognised in the specialties of nuclear medicine or radiation oncology on an admitted patient in a hospital. To be claimed once in the patient's lifetime only. (See para TN.3.1, TN.8.40 of explanatory notes to this Category) **Fee:** $379.60 **Benefit:** 75% = $284.70
Fee 35406	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.3.1, TN.8.40 of explanatory notes to this Category) **Fee:** $890.75 **Benefit:** 75% = $668.10
Fee 35408	Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.3.1, TN.8.40 of explanatory notes to this Category) **Fee:** $668.15 **Benefit:** 75% = $501.15
Fee 35410	UTERINE ARTERY CATHETERISATION with percutaneous administration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)

T8. SURGICAL OPERATIONS	3. VASCULAR
	(See para TN.8.34 of explanatory notes to this Category) **Fee:** $890.75 **Benefit:** 75% = $668.10 85% = $797.55
Fee 35412	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling (if performed), with parent artery preservation, not for use with liquid embolics only, including intra-operative imaging, but in association with pre-operative diagnostic imaging under item 60009, 60072, 60075 or 60078, including aftercare (Anaes.) (Assist.) (See para TN.8.35 of explanatory notes to this Category) **Fee:** $3,129.60 **Benefit:** 75% = $2347.20 85% = $3036.40
Fee 35414	Mechanical thrombectomy, in a patient with a diagnosis of acute ischaemic stroke caused by occlusion of a large vessel of the anterior cerebral circulation, including intra-operative imaging and aftercare, if: (a) the diagnosis is confirmed by an appropriate imaging modality such as computed tomography, magnetic resonance imaging or angiography; and (b) the service is performed by a specialist or consultant physician with appropriate training that is recognised by the Conjoint Committee for Recognition of Training in Interventional Neuroradiology; and (c) the service is provided in an eligible stroke centre. For any particular patient - applicable once per presentation by the patient at an eligible stroke centre, regardless of the number of times mechanical thrombectomy is attempted during that presentation (Anaes.) (Assist.) (See para TR.8.1 of explanatory notes to this Category) **Fee:** $3,833.30 **Benefit:** 75% = $2875.00

T8. SURGICAL OPERATIONS	4. GYNAECOLOGICAL
	Group T8. Surgical Operations
	Subgroup 4. Gynaecological
Fee 35500	GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $89.05 **Benefit:** 75% = $66.80 85% = $75.70
Fee 35503	Introduction of an intra-uterine device for abnormal uterine bleeding or contraception or for endometrial protection during oestrogen replacement therapy, if the service is not associated with a service to which another item in this Group applies (other than a service described in item 30062, 35506 or 35620) (Anaes.) **Fee:** $87.80 **Benefit:** 75% = $65.85 85% = $74.65
Fee 35506	Intra-uterine device, removal of under general anaesthesia, for a retained or embedded device, not being a service associated with a service to which another item in this Group applies (other than a service described in item 35503) (Anaes.)

	Fee: $58.80 **Benefit:** 75% = $44.10 85% = $50.00
Fee 35507	Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block), if the time taken is less than or equal to 45 minutes—other than a service associated with a service to which item 32236 applies (H) (Anaes.) **Fee:** $191.05 **Benefit:** 75% = $143.30
Fee 35508	Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block), if the time taken is greater than 45 minutes—other than a service associated with a service to which item 32236 applies (H) (Anaes.) (Assist.) **Fee:** $281.45 **Benefit:** 75% = $211.10
Fee 35509	HYMENECTOMY (Anaes.) **Fee:** $98.00 **Benefit:** 75% = $73.50 85% = $83.30
Fee 35513	Bartholin's abscess, cyst or gland, excision of (Anaes.) **Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
Fee 35517	Bartholin's abscess, cyst or gland, marsupialisation of (Anaes.) **Fee:** $159.95 **Benefit:** 75% = $120.00 85% = $136.00
Fee 35518	Ovarian cyst aspiration, for cysts of at least 4 cm in diameter in a premenopausal patient and at least 2 cm in diameter in a postmenopausal patient, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques, and not in cases of suspected or possible malignancy (Anaes.) (See para TN.4.11 of explanatory notes to this Category) **Fee:** $227.65 **Benefit:** 75% = $170.75 85% = $193.55
Fee 35527	Urethral caruncle, symptomatic excision of, if: (a) conservative management has failed; or (b) there is a suspicion of malignancy (Anaes.) **Fee:** $159.95 **Benefit:** 75% = $120.00 85% = $136.00
Fee 35533	Vulvoplasty or labioplasty, for repair of: (a) female genital mutilation; or (b) an anomaly associated with a major congenital anomaly of the uro-gynaecological tract other than a service associated with a service to which item 35536, 37836, 37050, 37842, 37851 or 43882 applies (Anaes.) (See para TN.8.123 of explanatory notes to this Category) **Fee:** $383.15 **Benefit:** 75% = $287.40
Fee 35534	Vulvoplasty or labioplasty, in a patient aged 18 years or more, performed by a specialist in the practice of the specialist's specialty, for a structural abnormality that is causing significant functional impairment, if the patient's labium extends more than 8 cm below the vaginal introitus while the patient is in a standing resting position (Anaes.) (See para TN.8.123 of explanatory notes to this Category) **Fee:** $383.15 **Benefit:** 75% = $287.40

	Vulva, wide local excision or hemivulvectomy, one or both procedures, for suspected malignancy or vulval lesions with a high risk of malignancy (Anaes.) (Assist.)
Fee 35536	(See para TN.8.235 of explanatory notes to this Category) **Fee:** $381.65 **Benefit:** 75% = $286.25 85% = $324.45
	Colposcopically directed laser therapy for histologically-confirmed high grade intraepithelial neoplastic changes of the vagina, vulva, urethra or anal canal, including any associated biopsies—one anatomical site (Anaes.)
Fee 35539	**Fee:** $298.95 **Benefit:** 75% = $224.25 85% = $254.15
	Colposcopically directed laser therapy for condylomata, unsuccessfully treated by other methods (Anaes.)
Fee 35545	**Fee:** $201.10 **Benefit:** 75% = $150.85 85% = $170.95
	VULVECTOMY, radical, for malignancy (H) (Anaes.) (Assist.)
Fee 35548	(See para TN.8.235, TN.8.239 of explanatory notes to this Category) **Fee:** $1,370.20 **Benefit:** 75% = $1027.65
	Pelvic lymph nodes, radical excision of, unilateral, or sentinel node dissection (including any pre-operative injection) (Anaes.) (Assist.)
Fee 35551	**Fee:** $1,012.80 **Benefit:** 75% = $759.60
	Pelvic lymph nodes, radical excision of, unilateral or sentinel node dissection, following similar previous dissection, radiation or chemotherapy (H) (Anaes.) (Assist.)
Fee 35552	**Fee:** $1,523.60 **Benefit:** 75% = $1142.70
	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.)
Fee 35554	**Fee:** $47.60 **Benefit:** 75% = $35.70 85% = $40.50
	Vagina, complete excision of benign tumour (including Gartner duct cyst), with histological documentation (Anaes.)
Fee 35557	(See para TN.8.237 of explanatory notes to this Category) **Fee:** $234.90 **Benefit:** 75% = $176.20 85% = $199.70
	Partial or complete vaginectomy, for either or both of the following: (a) deeply infiltrating vaginal endometriosis, if accompanied by histological confirmation from excised tissue; (b) pre-invasive or invasive lesions Not being a service associated with hysterectomy for non invasive indications (H) (Anaes.) (Assist.)
Fee 35560	(See para TN.8.235, TN.8.238 of explanatory notes to this Category) **Fee:** $749.05 **Benefit:** 75% = $561.80
	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (H) (Anaes.) (Assist.)
Fee 35561	(See para TN.8.235 of explanatory notes to this Category) **Fee:** $1,681.20 **Benefit:** 75% = $1260.90
	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (H) (Anaes.) (Assist.)
Fee 35562	(See para TN.8.235 of explanatory notes to this Category) **Fee:** $1,416.30 **Benefit:** 75% = $1062.25

Fee 35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (H) (Assist.) (See para TN.8.235 of explanatory notes to this Category) **Fee:** $708.15 **Benefit:** 75% = $531.15
Fee 35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.) **Fee:** $749.05 **Benefit:** 75% = $561.80
Fee 35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.) **Fee:** $435.05 **Benefit:** 75% = $326.30
Fee 35568	Procedures for the management of symptomatic upper vaginal (vault or cervical) prolapse by sacrospinous or ilococcygeus fixation (H) (Anaes.) (Assist.) **Fee:** $684.05 **Benefit:** 75% = $513.05
Fee 35569	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes.) **Fee:** $176.15 **Benefit:** 75% = $132.15
Fee 35570	Anterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving repair of urethrocele and cystocele; and (b) using native tissue without graft; other than a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $606.60 **Benefit:** 75% = $454.95
Fee 35571	Posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving repair of one or more of the following: (i) perineum; (ii) rectocoele; (iii) enterocoele; and (b) using native tissue without graft; other than a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $606.60 **Benefit:** 75% = $454.95
Fee 35573	Anterior and posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving anterior and posterior compartment defects; and (b) using native tissue without graft; other than a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $910.00 **Benefit:** 75% = $682.50

Fee 35577	Manchester (Donald Fothergill) operation for pelvic organ prolapse, involving either or both of the following: (a) cervical amputation; (b) anterior and posterior native tissue vaginal wall repairs without graft (Anaes.) (Assist.) **Fee:** $738.75 **Benefit:** 75% = $554.10
Fee 35578	Colpocleisis for pelvic organ prolapse, not being a service associated with a service to which another item (other than item 35599) in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $738.75 **Benefit:** 75% = $554.10
Fee 35581	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.) (See para TN.8.140 of explanatory notes to this Category) **Fee:** $606.60 **Benefit:** 75% = $454.95
Fee 35582	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), $2cm^2$ or more in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35581 or 35585 applies (Anaes.) (Assist.) (See para TN.8.140 of explanatory notes to this Category) **Fee:** $910.00 **Benefit:** 75% = $682.50
Fee 35585	Abdominal procedure, by open, laparoscopic or robot-assisted approach, if the service: (a) is for the removal of graft material: (i) in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure); or (ii) where the graft has penetrated adjacent organs such as the bladder (including urethra) or bowel; and (b) if required—includes retroperitoneal dissection, and mobilisation, of either or both of the bladder and bowel; other than a service associated with a service to which item 35581 or 35582 applies (Anaes.) (Assist.) **Fee:** $1,613.45 **Benefit:** 75% = $1210.10
Fee 35591	Rectovaginal fistula repair of, by vaginal route approach, not being a service associated with a service to which item 35592, 35596, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $1,012.80 **Benefit:** 75% = $759.60

Fee 35592	Vesicovaginal fistula closure of, by vaginal approach, not being a service associated with a service to which item 35591, 35596, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 35595	Procedure for the management of symptomatic vaginal vault or cervical prolapse, by uterosacral ligament suspension, by any approach, without graft, if the uterosacral ligaments are separately identified, transfixed and then incorporated into rectovaginal and pubocervical fascia of the vaginal vault, including cystoscopy to check ureteric integrity (H) (Anaes.) (Assist.) **Fee:** $684.05 **Benefit:** 75% = $513.05
Fee 35596	Fistula between genital and urinary or alimentary tracts, repair of, other than a service to which item 35591, 35592, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 35597	Sacral colpopexy, by any approach where graft or mesh is secured to vault, anterior and posterior compartments and to sacrum for correction of symptomatic upper vaginal vault prolapse (H) (Anaes.) (Assist.) **Fee:** $1,613.45 **Benefit:** 75% = $1210.10
Fee 35599	Stress incontinence, procedure using a female synthetic mid-urethral sling, with diagnostic cystoscopy to assess the integrity of the lower urinary tract, other than a service associated with a service to which item 36812 applies (H) (Anaes.) (Assist.) **Fee:** $830.05 **Benefit:** 75% = $622.55
Fee 35608	Cervix, one or more biopsies, cauterisation (other than by chemical means), ionisation, diathermy or endocervical curettage of, with or without dilatation of cervix (Anaes.) **Fee:** $70.05 **Benefit:** 75% = $52.55 85% = $59.55
Fee 35609	Cervix, cone biopsy or amputation (Anaes.) (See para TN.8.233, TN.8.235, TN.8.2 of explanatory notes to this Category) **Fee:** $238.75 **Benefit:** 75% = $179.10 85% = $202.95
Fee 35610	Cervix, cone biopsy for histologically proven malignancy (Anaes.) (See para TN.8.233, TN.8.235, TN.8.2 of explanatory notes to this Category) **Fee:** $417.80 **Benefit:** 75% = $313.35 85% = $355.15
Fee 35611	Removal of cervical or vaginal polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.) **Fee:** $70.05 **Benefit:** 75% = $52.55 85% = $59.55
Fee 35612	Cervix, residual stump, removal of, by abdominal approach for non-malignant lesions (Anaes.) (Assist.) **Fee:** $554.15 **Benefit:** 75% = $415.65 85% = $471.05
Fee 35614	Examination of the lower genital tract using a colposcope in a patient who: (a) has a human papilloma virus related gynaecology indication; or (b) has symptoms or signs suspicious of lower genital tract malignancy; or (c) is undergoing follow-up treatment of lower genital tract malignancy; or (d) is undergoing assessment or surveillance of a vulvovaginal pre-malignant or malignant disease; or (e) is undergoing assessment or surveillance as part of an identified at risk population (See para TN.8.42, TN.8.233 of explanatory notes to this Category)

	Fee: $69.95 **Benefit:** 75% = $52.50 85% = $59.50
Fee 35615	Vulva or vagina, biopsy of, when performed in conjunction with a service to which item 35614 applies **Fee:** $77.10 **Benefit:** 75% = $57.85 85% = $65.55
Fee 35616	Endometrial ablation by thermal balloon or radiofrequency electrosurgery, for abnormal uterine bleeding, with or without endometrial sampling, including any hysteroscopy performed on the same day (H) (Anaes.) **Fee:** $492.40 **Benefit:** 75% = $369.30
Fee 35620	Endometrial biopsy for pathological assessment in women with abnormal uterine bleeding or post-menopausal bleeding (Anaes.) **Fee:** $58.45 **Benefit:** 75% = $43.85 85% = $49.70
Fee 35622	Endometrial ablation, using hysteroscopically guided electrosurgery or laser energy for abnormal uterine bleeding, with or without endometrial sampling, not being a service associated with a service to which item 30390 applies (H) (Anaes.) **Fee:** $659.90 **Benefit:** 75% = $494.95
Fee 35623	Endometrial ablation and resection of myoma or uterine septum (or both), using hysteroscopic guided electrosurgery or laser energy, for abnormal uterine bleeding, with or without endometrial sampling (H) (Anaes.) **Fee:** $897.30 **Benefit:** 75% = $673.00
Fee 35626	Hysteroscopy for investigation of suspected intrauterine pathology, with or without local anaesthesia, including any associated endometrial biopsy, not being a service associated with a service to which item 35630 applies (See para TN.8.43 of explanatory notes to this Category) **Fee:** $245.40 **Benefit:** 75% = $184.05 85% = $208.60
Fee 35630	Hysteroscopy for investigation of suspected intrauterine pathology if performed under general anaesthesia, including any associated endometrial biopsy, not being a service associated with a service to which item 35626 applies (H) (Anaes.) **Fee:** $200.45 **Benefit:** 75% = $150.35
Fee 35631	Operative laparoscopy, including any of the following: (a) unilateral or bilateral ovarian cystectomy; (b) salpingo-oophorectomy; (c) salpingectomy for tubal pathology (including ectopic pregnancy by tubal removal or salpingostomy, but excluding sterilisation); (d) excision of mild endometriosis; not being a service associated with a service to which any other intraperitoneal or retroperitoneal procedure item (other than item 30724 or 30725) applies (H) (Anaes.) (Assist.) (See para TN.8.248, TN.8.229, TN.1.4, TN.8.2 of explanatory notes to this Category) **Fee:** $779.30 **Benefit:** 75% = $584.50
Fee 35632	Complicated operative laparoscopy, including either or both of the following: (a) excision of moderate endometriosis; (b) laparoscopic myomectomy for a myoma of at least 4cm, including incision and repair of the uterus; not being a service associated with a service to which any other intraperitoneal or retroperitoneal procedure item (other than item 30724 or 30725 or 35658) applies (H) (Anaes.) (Assist.) (See para TN.8.248, TN.8.229, TN.1.4, TN.8.2 of explanatory notes to this Category)

	Fee: $974.05 **Benefit:** 75% = $730.55
Fee 35633	Hysteroscopy, under visual guidance, including any of the following: (a) removal of an intra-uterine device; (b) removal of polyps by any method; (c) division of minor intrauterine adhesions (Anaes.) (See para TN.8.249 of explanatory notes to this Category) **Fee:** $238.75 **Benefit:** 75% = $179.10 85% = $202.95
Fee 35635	Hysteroscopy involving division of: (a) a uterine septum; or (b) moderate to severe intrauterine adhesions (H) (Anaes.) (See para TN.8.249 of explanatory notes to this Category) **Fee:** $328.00 **Benefit:** 75% = $246.00
Fee 35636	Hysteroscopy, resection of myoma or myoma and uterine septum (if both are performed) (H) (Anaes.) **Fee:** $474.25 **Benefit:** 75% = $355.70
Fee 35637	Operative laparoscopy, including any of the following: (a) excision or ablation of minimal endometriosis; (b) division of pathological adhesions; (c) sterilisation by application of clips, division, destruction or removal of tubes; not being a service associated with another laparoscopic procedure (H) NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim. (Anaes.) (Assist.) (See para TN.1.4, TN.8.248, TN.8.229, TN.8.46 of explanatory notes to this Category) **Fee:** $445.30 **Benefit:** 75% = $334.00
Fee 35640	Uterus, curettage of, with or without dilation (including curettage for incomplete miscarriage), if performed under: (a) general anaesthesia; or (b) epidural or spinal (intrathecal) nerve block; or (c) sedation; including procedures (if performed) to which item 35626 or 35630 applies (Anaes.) (See para TN.8.44 of explanatory notes to this Category) **Fee:** $200.45 **Benefit:** 75% = $150.35 85% = $170.40
Fee 35641	Severe endometriosis, laparoscopic resection of, involving 2 of the following procedures: (a) resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter; (b) resection of the Pouch of Douglas; (c) resection of an ovarian endometrioma greater than 2 cm in diameter; (d) dissection of bowel from uterus from the level of the endocervical junction or above (H) (Anaes.) (Assist.) (See para TN.8.248, TN.8.229, TN.1.4 of explanatory notes to this Category) **Fee:** $1,361.05 **Benefit:** 75% = $1020.80
Fee 35643	Evacuation of the contents of the gravid uterus by curettage or suction curettage, if performed under: (a) local anaesthesia; or (b) general anaesthesia; or (c) epidural or spinal (intrathecal) nerve block; or

	(d) sedation; including procedures (if performed) to which item 35626 or 35630 applies (Anaes.) **Fee:** $238.75 **Benefit:** 75% = $179.10 85% = $202.95
Fee 35644	Cervix, ablation by electrocoagulation diathermy, laser or cryotherapy, with colposcopy, including any local anaesthesia and biopsies, for previously biopsy confirmed HSIL (CIN 2/3) in a patient with a Type 1 or 2 (completely visible) transformation zone, if there is: (a) no evidence of invasive or glandular disease; and (b) no discordance between cytology and previous histology; not being a service associated with a service to which item 35647 or 35648 applies (Anaes.) (See para TN.8.45, TN.8.234 of explanatory notes to this Category) **Fee:** $223.05 **Benefit:** 75% = $167.30 85% = $189.60
Fee 35645	Cervix, ablation by electrocoagulation diathermy, laser or cryotherapy, with colposcopy, including any local anaesthesia or biopsies, in conjunction with ablative therapy of additional areas of biopsy proven high grade intraepithelial lesions of one or more sites of the vagina, vulva, urethra or anus, for previously biopsy confirmed HSIL (CIN2/3) in a patient with a Type 1 of 2 (completely visible) transformation zone, if there is: (a) no evidence of invasive or glandular disease; and (b) no discordance between cytology and previous histology; not being a service associated with a service to which item 35647 or 35648 applies (Anaes.) (See para TN.8.45, TN.8.234 of explanatory notes to this Category) **Fee:** $349.05 **Benefit:** 75% = $261.80 85% = $296.70
Fee 35647	Cervix, complete excision of the endocervical transformation zone, using large loop or laser therapy, including any local anaesthesia and biopsies (Anaes.) (See para TN.8.45, TN.8.233, TN.8.235 of explanatory notes to this Category) **Fee:** $223.05 **Benefit:** 75% = $167.30 85% = $189.60
Fee 35648	Cervix, complete excision of the endocervical transformation zone, using large loop or laser therapy, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of biopsy-proven high grade intraepithelial lesions of one or more sites of the vagina, vulva, urethra or anus (Anaes.) (See para TN.8.45, TN.8.233, TN.8.235 of explanatory notes to this Category) **Fee:** $349.05 **Benefit:** 75% = $261.80 85% = $296.70
Fee 35649	Myomectomy, one or more myomas, when undertaken by an open abdominal approach (H) (Anaes.) (Assist.) **Fee:** $587.00 **Benefit:** 75% = $440.25
Fee 35653	Hysterectomy, abdominal, with or without removal of fallopian tubes and ovaries (H) (Anaes.) (Assist.) (See para TN.8.232 of explanatory notes to this Category) **Fee:** $739.00 **Benefit:** 75% = $554.25
Fee 35657	Hysterectomy, vaginal, with or without uterine curettage, inclusive of posterior culdoplasty, not being a service associated with a service to which item 35673 applies (H) (Anaes.) (Assist.) **Fee:** $739.00 **Benefit:** 75% = $554.25

	Uterus (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal or laparoscopic removal at hysterectomy or myoma of at least 4 cm removed by laparoscopy when retrieved from the abdomen (H) (Anaes.) (Assist.)
Fee 35658	(See para TN.8.47, TN.8.229 of explanatory notes to this Category) **Fee:** $455.70 **Benefit:** 75% = $341.80
	Hysterectomy, abdominal, that concurrently requires extensive retroperitoneal dissection with exposure of one or both ureters and complex side wall dissection, including when performed with one or more of the following procedures: (a) salpingectomy; (b) oophorectomy; (c) excision of ovarian cyst (H) (Anaes.) (Assist.)
Fee 35661	(See para TN.8.232 of explanatory notes to this Category) **Fee:** $1,847.65 **Benefit:** 75% = $1385.75
	Radical hysterectomy or radical trachelectomy (with or without excision of uterine adnexae) for proven malignancy, including excision of any one or more of the following: (a) parametrium; (b) paracolpos; (c) upper vagina; (d) contiguous pelvic peritoneum; utilising nerve sparing techniques and involving ureterolysis, if performed (H) (Anaes.) (Assist.)
Fee 35667	(See para TN.8.235 of explanatory notes to this Category) **Fee:** $1,745.20 **Benefit:** 75% = $1308.90
	Hysterectomy, radical (with or without excision of uterine adnexae) including excision of any one or more of the following: (a) parametrium; (b) paracolpos; (c) upper vagina; (d) contiguous pelvic peritoneum; utilising nerve sparing techniques and involving ureterolysis, if performed in a patient with malignancy and previous pelvic radiation or chemotherapy treatment (H) (Anaes.) (Assist.)
Fee 35668	(See para TN.8.235, TN.8.2 of explanatory notes to this Category) **Fee:** $2,027.60 **Benefit:** 75% = $1520.70
	Hysterectomy, peripartum, performed for histologically proven placenta increta or percreta, or placenta accreta, if the patient has been referred to another practitioner for the management of severe intractable peripartum haemorrhage (H) (Anaes.) (Assist.)
Fee 35669	(See para TN.8.2 of explanatory notes to this Category) **Fee:** $2,027.60 **Benefit:** 75% = $1520.70
	Hysterectomy, peripartum, for ongoing intractable haemorrhage where other haemorrhage control techniques have failed, for the purpose of providing lifesaving emergency treatment, not being a service associated with a service to which item 35667, 35668 or 35669 applies (H) (Anaes.) (Assist.)
Fee 35671	(See para TN.8.2 of explanatory notes to this Category) **Fee:** $1,590.55 **Benefit:** 75% = $1192.95
Fee 35673	Hysterectomy, vaginal, with or without uterine curettage, with salpingectomy, oophorectomy or excision of ovarian cyst, one or more, one or both sides, inclusive of a posterior culdoplasty, not being a service associated with a service to which item 35657 applies (H) (Anaes.) (Assist.)

	Fee: $829.95 **Benefit:** 75% = $622.50
Fee 35674	ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy (See para TN.4.11 of explanatory notes to this Category) **Fee:** $227.65 **Benefit:** 75% = $170.75 85% = $193.55
Fee 35680	BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.) **Fee:** $637.45 **Benefit:** 75% = $478.10 85% = $544.25
Fee 35691	STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section NOTE: *Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explantory note before submitting a claim.* (Anaes.) (Assist.) (See para TN.8.46 of explanatory notes to this Category) **Fee:** $173.80 **Benefit:** 75% = $130.35
Fee 35694	Tuboplasty (salpingostomy or salpingolysis), unilateral or bilateral, one or more procedures (H) (Anaes.) (Assist.) **Fee:** $698.35 **Benefit:** 75% = $523.80
Fee 35697	Microsurgical or laparoscopic tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.) **Fee:** $1,036.30 **Benefit:** 75% = $777.25
Fee 35700	FALLOPIAN TUBES, unilateral microsurgical or laparoscopic anastomosis of (H) (Anaes.) (Assist.) **Fee:** $799.65 **Benefit:** 75% = $599.75
Fee 35703	HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure (Anaes.) (See para TN.8.230 of explanatory notes to this Category) **Fee:** $73.95 **Benefit:** 75% = $55.50 85% = $62.90
Fee 35717	Laparotomy, involving oophorectomy, salpingectomy, salpingo-oophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst—one or more such procedures, unilateral or bilateral, including adhesiolysis, for benign disease (including ectopic pregnancy by tubal removal or salpingostomy), not being a service associated with hysterectomy (H) (Anaes.) (Assist.) (See para TN.8.232 of explanatory notes to this Category) **Fee:** $934.40 **Benefit:** 75% = $700.80
Fee 35720	Radical debulking, involving the radical excision of a macroscopically disseminated gynaecological malignancy from the pelvic cavity, including resection of peritoneum from the following: (a) the pelvic side wall; (b) the pouch of Douglas; (c) the bladder; for macroscopic disease confined to the pelvis, not being a service associated with a service to which item 35721 applies (H) (Anaes.) (Assist.) (See para TN.8.57, TN.8.235 of explanatory notes to this Category)

	Fee: $1,746.80 **Benefit:** 75% = $1310.10
	Radical debulking, involving the radical excision of a macroscopically disseminated gynaecological malignancy from the abdominal and pelvic cavity, where cancer has extended beyond the pelvis, including any of the following: (a) resection of peritoneum over any of the following: (i) the diaphragm; (ii) the paracolic gutters; (iii) the greater or lesser omentum; (iv) the porta hepatis; (b) cytoreduction of recurrent gynaecological malignancy from the abdominal cavity following previous abdominal surgery, radiation or chemotherapy; (c) cytoreduction of recurrent gynaecological malignancy from the pelvic cavity following previous pelvic surgery, radiation or chemotherapy; not being a service to which a service associated with a service to which item 35720 or 35726 applies (H) (Anaes.) (Assist.)
Fee 35721	(See para TN.8.235, TN.8.236, TN.8.2 of explanatory notes to this Category) **Fee:** $3,493.65 **Benefit:** 75% = $2620.25
	Para-aortic lymph node dissection from above the level of the aortic bifurcation (unilateral), for staging or restaging of gynaecological malignancy (H) (Anaes.) (Assist.)
Fee 35723	(See para TN.8.233, TN.8.235 of explanatory notes to this Category) **Fee:** $1,519.15 **Benefit:** 75% = $1139.40
	Para-aortic lymph node dissection (pelvic or above the aortic bifurcation) after prior similar dissection, radiotherapy or chemotherapy for malignancy (H) (Anaes.) (Assist.)
Fee 35724	(See para TN.8.233, TN.8.235, TN.8.2 of explanatory notes to this Category) **Fee:** $2,285.45 **Benefit:** 75% = $1714.10
	Infra-colic omentectomy, with or without multiple peritoneal biopsies, for staging or restaging of gynaecological malignancy, not being a service associated with a service to which item 35721 applies (H) (Anaes.) (Assist.)
Fee 35726	**Fee:** $529.15 **Benefit:** 75% = $396.90
	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.)
Fee 35729	**Fee:** $238.55 **Benefit:** 75% = $178.95
	Ovarian repositioning for one or both ovaries to preserve ovarian function, prior to gonadotoxic radiotherapy when the treatment volume and dose of radiation have a high probability of causing infertility (Anaes.)
Fee 35730	**Fee:** $238.55 **Benefit:** 75% = $178.95
	Hysterectomy, laparoscopic assisted vaginal, by any approach, including any endometrial sampling, with or without removal of the tubes or ovarian cystectomy or removal of the ovaries and tubes due to other pathology, not being a service associated with a service to which item 35595 or 35673 applies. (H) (Anaes.) (Assist.)
Fee 35750	(See para TN.8.229, TN.8.231 of explanatory notes to this Category) **Fee:** $859.30 **Benefit:** 75% = $644.50

T8. SURGICAL OPERATIONS	4. GYNAECOLOGICAL
Fee 35751	Hysterectomy, laparoscopic, by any approach, including any endometrial sampling, with or without removal of the tubes, not being a service associated with a service to which item 35595 applies (H) (Anaes.) (Assist.) (See para TN.8.229, TN.8.231, TN.8.2 of explanatory notes to this Category) **Fee:** $859.30 **Benefit:** 75% = $644.50
Fee 35753	Hysterectomy, complex laparoscopic, by any approach, including endometrial sampling, with either or both of the following procedures: (a) unilateral or bilateral salpingo-oophorectomy (excluding salpingectomy); (b) excision of moderate endometriosis or ovarian cyst; including any associated laparoscopy, not being a service associated with a service to which item 35595 applies (H) (Anaes.) (Assist.) (See para TN.8.229, TN.8.231 of explanatory notes to this Category) **Fee:** $950.20 **Benefit:** 75% = $712.65
Fee 35754	Hysterectomy, complex laparoscopic, by any approach, that concurrently requires either extensive retroperitoneal dissection or complex side wall dissection, or both, with any of the following procedures (if performed): (a) endometrial sampling; (b) unilateral or bilateral salpingectomy, oophorectomy or salpingo-oophorectomy; (c) excision of ovarian cyst; (d) any other associated laparoscopy; not being a service associated with a service to which item 35595 or 35641 applies (H) (Anaes.) (Assist.) (See para TN.8.229, TN.8.231 of explanatory notes to this Category) **Fee:** $1,836.05 **Benefit:** 75% = $1377.05
Fee 35756	Hysterectomy, laparoscopic, by any approach, if the procedure is completed by open hysterectomy for control of bleeding or extensive pathology, including any associated laparoscopy, not being a service associated with a service to which item 35595 or 35641 applies (H) (Anaes.) (Assist.) (See para TN.8.229, TN.8.231 of explanatory notes to this Category) **Fee:** $1,567.15 **Benefit:** 75% = $1175.40
Fee 35759	Procedure for the control of post operative haemorrhage following gynaecological surgery, under general anaesthesia, utilising a vaginal, abdominal or laparoscopic approach if no other procedure is performed (H) (Anaes.) (Assist.) **Fee:** $617.00 **Benefit:** 75% = $462.75

T8. SURGICAL OPERATIONS	5. UROLOGICAL
	Group T8. Surgical Operations
	Subgroup 5. Urological
Fee 37046	Suprapubic or perineal procedure for excision of graft material, either singly or in multiple pieces, for a symptomatic patient with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), if not more than one service to which this item applies has been provided to the patient by the same practitioner in the preceding 12 months (Anaes.) (Assist.) **Fee:** $758.40 **Benefit:** 75% = $568.80

Fee 37226 S	Prostate or prostatic bed, needle biopsy of, using prostatic magnetic resonance imaging techniques and obtaining 1 or more prostatic specimens. (Anaes.) (Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $307.65 **Benefit:** 75% = $230.75 85% = $261.55
	GENERAL
Fee 36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $749.05 **Benefit:** 75% = $561.80
Fee 36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) **Fee:** $1,523.60 **Benefit:** 75% = $1142.70
Fee 36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) **Fee:** $857.55 **Benefit:** 75% = $643.20
Fee 36516	Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 36519	Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, complicated by previous surgery on the same kidney, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,414.10 **Benefit:** 75% = $1060.60
Fee 36522	Nephrectomy, partial, by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,213.50 **Benefit:** 75% = $910.15
Fee 36525	Nephrectomy, partial, by open, laparoscopic or robot-assisted approach: (a) if complicated by previous surgery or ablative procedure on the same kidney; or (b) for a patient with a solitary functioning kidney; or (c) for a patient with an estimated glomerular filtration rate (eGFR) of less than 60ml/min/1.73m^2; other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) **Fee:** $1,724.35 **Benefit:** 75% = $1293.30

Fee 36528	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cm in diameter, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,414.10 **Benefit:** 75% = $1060.60
Fee 36529	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy: (a) for a tumour 10 cm or more in diameter; or (b) if complicated by previous open or laparoscopic surgery on the same kidney; other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,745.20 **Benefit:** 75% = $1308.90
Fee 36530 S	Renal cell carcinoma, not more than 4 cm in diameter, destruction of, by percutaneous, laparoscopic or open cryoablation (including any associated imaging services), if: (a) malignancy has previously been confirmed by histopathological examination; and (b) a multi-disciplinary team has reviewed treatment options for the patient and assessed that partial nephrectomy is not suitable; and (c) the service is not a service associated with a service to which item 36522 or 36525 applies (H) (Anaes.) **Fee:** $886.90 **Benefit:** 75% = $665.20
Fee 36531	Nephroureterectomy, complete, by open, laparoscopic or robot-assisted approach, including associated bladder repair and any associated endoscopic procedure, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,268.15 **Benefit:** 75% = $951.15
Fee 36532	Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, other than a service to which item 36533 applies or a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,820.10 **Benefit:** 75% = $1365.10
Fee 36533	Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, if complicated by previous open or laparoscopic surgery on the same kidney or ureter, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $2,151.25 **Benefit:** 75% = $1613.45
Fee 36537	KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $757.20 **Benefit:** 75% = $567.90

Fee 36543	Nephrolithotomy or pyelolithotomy, or both, extended, for one or more renal stones, including one or more of nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.) **Fee:** $1,414.10 **Benefit:** 75% = $1060.60 85% = $1320.90
Fee 36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.) **Fee:** $757.20 **Benefit:** 75% = $567.90 85% = $664.00
Fee 36549	Ureterolithotomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.) **Fee:** $912.45 **Benefit:** 75% = $684.35
Fee 36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 36558	RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.) **Fee:** $711.70 **Benefit:** 75% = $533.80 85% = $618.50
Fee 36561	Renal biopsy, performed under image guidance (closed) (Anaes.) **Fee:** $188.90 **Benefit:** 75% = $141.70 85% = $160.60
Fee 36564	Pyeloplasty, (plastic reconstruction of the pelvi-ureteric junction) by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 36567	Pyeloplasty in a kidney that is congenitally abnormal (in addition to the presence of pelvi-ureteric junction obstruction), or in a solitary kidney, by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.) (See para TN.8.155 of explanatory notes to this Category) **Fee:** $1,113.10 **Benefit:** 75% = $834.85
Fee 36570	Pyeloplasty, complicated by previous surgery on the same kidney, by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.) **Fee:** $1,414.10 **Benefit:** 75% = $1060.60
Fee 36573	DIVIDED URETER, repair of (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 36576	Kidney, exposure and exploration of, including repair or nephrectomy, for trauma, by open, laparoscopic or robot-assisted approach, other than a service associated with: (a) any other procedure performed on the kidney, renal pelvis or renal pedicle; or (b) a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,268.15 **Benefit:** 75% = $951.15
Fee 36579	Ureterectomy, complete or partial: (a) for a tumour within the ureter, proven by histopathology at the time of surgery; or

	(b) for congenital anomaly; with or without associated bladder repair (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 36585	URETER, transplantation of, into skin (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 36588	URETER, reimplantation into bladder (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) **Fee:** $1,213.50 **Benefit:** 75% = $910.15
Fee 36594	URETER, transplantation of, into intestine (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.) (See para TN.8.153 of explanatory notes to this Category) **Fee:** $1,213.50 **Benefit:** 75% = $910.15 85% = $1120.30
Fee 36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) (See para TN.8.153 of explanatory notes to this Category) **Fee:** $1,414.10 **Benefit:** 75% = $1060.60
Fee 36604	Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional radiology techniques, but not including imaging (Anaes.) **Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25
Fee 36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) **Fee:** $2,536.35 **Benefit:** 75% = $1902.30
Fee 36607	Ureteric stent insertion of, with balloon dilatation of: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional radiology techniques, but not including imaging (Anaes.) **Fee:** $756.50 **Benefit:** 75% = $567.40
Fee 36608	Ureteric stent, exchange of, percutaneously through either the ileal conduit or bladder, using interventional radiology techniques, but not including imaging, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.)

	Fee: $293.20 **Benefit:** 75% = $219.90
Fee 36609	Intestinal urinary conduit, reservoir or ureterostomy, revision of (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 36610	Intestinal urinary conduit, incontinent, formation of (including associated small bowel resection and anastomosis), including implantation of one or both ureters into reservoir (Anaes.) (Assist.) **Fee:** $1,944.05 **Benefit:** 75% = $1458.05
Fee 36611	Intestinal urinary reservoir, continent, formation of (including associated small bowel resection and anastomosis), including formation of non-return valves and implantation of one or both ureters into reservoir, performed by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.) **Fee:** $3,066.35 **Benefit:** 75% = $2299.80
Fee 36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) **Fee:** $711.70 **Benefit:** 75% = $533.80
Fee 36615	Ureterolysis, unilateral, with or without repositioning of the ureter, for obstruction of the ureter, if: (a) the obstruction: (i) is evident either radiologically or by proximal ureteric dilatation at operation; and (ii) is secondary to retroperitoneal fibrosis; and (b) there is biopsy proven fibrosis, endometriosis or cancer at the site of the obstruction at time of surgery (Anaes.) (Assist.) (See para TN.8.156 of explanatory notes to this Category) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.) **Fee:** $711.70 **Benefit:** 75% = $533.80
Fee 36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) **Fee:** $508.80 **Benefit:** 75% = $381.60
Fee 36624	Nephrostomy, percutaneous, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.) **Fee:** $611.30 **Benefit:** 75% = $458.50 85% = $519.65
Fee 36627	Nephroscopy, percutaneous, with or without any one or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639 or 36645 applies (Anaes.) **Fee:** $757.20 **Benefit:** 75% = $567.90
Fee 36633	Nephroscopy, percutaneous, with incision of any one or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639 or 36645 applies (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10 85% = $718.90
Fee 36636	Nephroscopy, percutaneous, with incision of any one or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639 or 36645 applies (Anaes.) (Assist.)

	Fee: $437.95 **Benefit:** 75% = $328.50
Fee 36639	Nephroscopy, percutaneous, with destruction and extraction of one or two stones using ultrasound or electrohydraulic shock waves or lasers, other than a service to which item 36645 applies (Anaes.) **Fee:** $912.45 **Benefit:** 75% = $684.35
Fee 36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes.) (Assist.) **Fee:** $1,167.85 **Benefit:** 75% = $875.90
Fee 36649	Nephrostomy drainage tube, exchange of, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.) **Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25
Fee 36650	Nephrostomy tube, removal of, using interventional radiology techniques, but not including imaging, if the ureter has been stented with a double J ureteric stent and that stent is left in place (Anaes.) **Fee:** $164.00 **Benefit:** 75% = $123.00
Fee 36652	PYELOSCOPY, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803, 36812 or 36824 applies (Anaes.) (Assist.) **Fee:** $711.70 **Benefit:** 75% = $533.80
Fee 36654	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus 1 or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, not being a service associated with a service to which item 36656 applies to a procedure performed in the same collecting system (Anaes.) (Assist.) **Fee:** $912.45 **Benefit:** 75% = $684.35
Fee 36656	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction of fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Anaes.) (Assist.) **Fee:** $1,167.85 **Benefit:** 75% = $875.90
	OPERATIONS ON BLADDER
Fee 36504	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with biopsy of bladder, not being a service associated with a service to which item 36505, 36507, 36508, 36812, 36830, 36836, 36840, 36845, 36848, 36854, 37203, 37206, 37215, 37230 or 37233 applies. (Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $322.90 **Benefit:** 75% = $242.20 85% = $274.50
Fee 36505	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies.

	(Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $253.75 **Benefit:** 75% = $190.35 85% = $215.70
Fee 36507	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36840 or 36845 applies. (Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $425.10 **Benefit:** 75% = $318.85 85% = $361.35
Fee 36508	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.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $828.45 **Benefit:** 75% = $621.35 85% = $735.25
Fee 36663	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.) **Fee:** $723.90 **Benefit:** 75% = $542.95 85% = $630.70
Fee 36664	Both: (a) percutaneous repositioning of sacral nerve lead or leads using fluoroscopic guidance, or open repositioning of sacral nerve lead or leads; and (b) intra-operative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of: (i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment —other than a service to which item 36663 applies (Anaes.)

	Fee: $650.10 **Benefit:** 75% = $487.60 85% = $556.90
Fee 36665	Sacral nerve electrode or electrodes, management and adjustment of the pulse generator by a medical practitioner, to manage detrusor overactivity or non obstructive urinary retention - each day **Fee:** $137.30 **Benefit:** 75% = $103.00 85% = $116.75
Fee 36666	Pulse generator, subcutaneous placement of, and placement and connection of extension wire or wires to sacral nerve electrode or electrodes, for the management of: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.) **Fee:** $365.80 **Benefit:** 75% = $274.35 85% = $310.95
Fee 36667	Sacral nerve lead or leads, removal of, if the lead was inserted to manage: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.) **Fee:** $171.20 **Benefit:** 75% = $128.40 85% = $145.55
Fee 36668	Pulse generator, removal of, if the pulse generator was inserted to manage: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.) **Fee:** $171.20 **Benefit:** 75% = $128.40 85% = $145.55
Fee 36671	Percutaneous tibial nerve stimulation, initial treatment protocol, for the treatment of overactive bladder, by a specialist urologist, gynaecologist or urogynaecologist, if: (a) the patient has been diagnosed with idiopathic overactive bladder; and (b) the patient has been refractory to, is contraindicated or otherwise not suitable for conservative treatments (including anti-cholinergic agents); and (c) the patient is contraindicated or otherwise not a suitable candidate for botulinum toxin type A therapy; and (d) the patient is contraindicated or otherwise not a suitable candidate for sacral nerve stimulation; and (e) the patient is willing and able to comply with the treatment protocol; and

	(f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month period; and (g) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. For each patient—applicable only once, unless the patient achieves at least a 50% reduction in overactive bladder symptoms from baseline at any time during the 3 month treatment period. Not applicable for a service associated with a service to which item 36672 or 36673 applies **Fee:** $219.05 **Benefit:** 75% = $164.30 85% = $186.20
Fee 36672	Percutaneous tibial nerve stimulation, tapering treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if: (a) the patient responded to the percutaneous tibial nerve stimulation initial 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 tapering treatment protocol comprises no more than 5 sessions, delivered over a 3 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 a service associated with a service to which item 36671 or 36673 applies **Fee:** $219.05 **Benefit:** 75% = $164.30 85% = $186.20
Fee 36673	Percutaneous tibial nerve stimulation, maintenance treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation 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 applies **Fee:** $219.05 **Benefit:** 75% = $164.30 85% = $186.20
Fee 36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes.) **Fee:** $30.20 **Benefit:** 75% = $22.65 85% = $25.70

	Ureteroscopy, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824 or 36848 applies (Anaes.) (Assist.) (See para TN.8.51 of explanatory notes to this Category)
Fee 36803	**Fee:** $510.75 **Benefit:** 75% = $383.10 85% = $434.15
	Ureteroscopy, of one ureter: (a) with or without one or more of the following: (i) cystoscopy; (ii) endoscopic incision of pelviureteric junction or ureteric stricture; (iii) ureteric meatotomy; (iv) ureteric dilatation; and (b) with either or both of the following: (i) extraction of stone from the ureter; (ii) biopsy or diathermy of the ureter; other than: (c) a service associated with a service to which item 36803 or 36812 applies; or (d) a service associated with a service, performed on the same ureter, to which item 36809, 36824 or 36848 applies (Anaes.) (Assist.)
Fee 36806	**Fee:** $711.70 **Benefit:** 75% = $533.80
	Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824 or 36848 applies to a procedure performed on the same ureter (Anaes.) (Assist.)
Fee 36809	**Fee:** $912.45 **Benefit:** 75% = $684.35
	Cystoscopy, with insertion of one or more urethral or prostatic prostheses, other than a service associated with a service to which item 37203, 37207 or 37230 applies (Anaes.)
Fee 36811	**Fee:** $354.20 **Benefit:** 75% = $265.65 85% = $301.10
	Either or both of cystoscopy and urethroscopy, with or without urethral dilatation, other than a service associated with any other urological endoscopic procedure on the lower urinary tract (Anaes.)
Fee 36812	**Fee:** $182.60 **Benefit:** 75% = $136.95 85% = $155.25
	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (Anaes.) (See para TN.8.9 of explanatory notes to this Category)
Fee 36815	**Fee:** $260.55 **Benefit:** 75% = $195.45 85% = $221.50

Fee 36818	Cystoscopy, with ureteric catheterisation, unilateral or bilateral, guided by fluoroscopic imaging of the upper urinary tract, other than a service associated with a service to which item 36824 or 36830 applies (Anaes.) **Fee:** $302.95 **Benefit:** 75% = $227.25 85% = $257.55
Fee 36821	Cystoscopy with one or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral (Anaes.) (Assist.) **Fee:** $354.00 **Benefit:** 75% = $265.50 85% = $300.90
Fee 36822	Cystoscopy, with ureteric catheterisation, unilateral: (a) guided by fluoroscopic imaging of the upper urinary tract; and (b) including one or more of ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis; other than a service associated with a service to which item 36818, 36821 or 36830 applies (Anaes.) (Assist.) **Fee:** $505.50 **Benefit:** 75% = $379.15 85% = $429.70
Fee 36823	Cystoscopy, with removal of ureteric stent and ureteric catheterisation, unilateral: (a) guided by fluoroscopic imaging of the upper urinary tract; and (b) including either or both of the following: (i) ureteric dilatation; or (ii) insertion of ureteric stent of ureter or of renal pelvis; other than a service associated with a service to which item 36818, 36821, 36830 or 36833 applies (Anaes.) (Assist.) **Fee:** $581.25 **Benefit:** 75% = $435.95 85% = $494.10
Fee 36824	Cystoscopy, with ureteric catheterisation, unilateral or bilateral, other than a service associated with a service to which item 36818 applies (Anaes.) **Fee:** $233.45 **Benefit:** 75% = $175.10 85% = $198.45
Fee 36827	Cystoscopy, with controlled hydrodilatation of the bladder, other than a service associated with a service to which item 37011 or 37245 applies (Anaes.) **Fee:** $251.80 **Benefit:** 75% = $188.85 85% = $214.05
Fee 36830	CYSTOSCOPY, with ureteric meatotomy (Anaes.) **Fee:** $222.65 **Benefit:** 75% = $167.00
Fee 36833	Cystoscopy, with removal of ureteric stent or other foreign body in the lower urinary tract, unilateral (Anaes.) **Fee:** $302.95 **Benefit:** 75% = $227.25 85% = $257.55
Fee 36836	CYSTOSCOPY, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203, 37206, 37215, 37230 or 37233 applies (Anaes.) (See para TN.8.2 of explanatory notes to this Category)

	Fee: $251.80 **Benefit:** 75% = $188.85 85% = $214.05
Fee 36840	Cystoscopy, with diathermy, resection or visual laser destruction of bladder tumour or other lesion of the bladder, for: (a) a tumour or lesion in only one quadrant of the bladder; or (b) a solitary tumour of not more than 2 cm in diameter; other than a service associated with a service to which item 36845 applies (Anaes.) **Fee:** $354.00 **Benefit:** 75% = $265.50 85% = $300.90
Fee 36842	Cystoscopy, with lavage of blood clots from bladder, including any associated cautery of prostate or bladder, other than a service associated with a service to which any of items 36812, 36827 to 36863, 37203, 37206, 37230 and 37233 apply (Anaes.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $356.10 **Benefit:** 75% = $267.10
Fee 36845	Cystoscopy, with diathermy, resection or visual laser destruction of: (a) multiple tumours in 2 or more quadrants of the bladder; or (b) a solitary bladder tumour of more than 2 cm in diameter (Anaes.) **Fee:** $757.20 **Benefit:** 75% = $567.90 85% = $664.00
Fee 36848	CYSTOSCOPY, with resection of ureterocele (Anaes.) **Fee:** $251.80 **Benefit:** 75% = $188.85
Fee 36851	Cystoscopy, with injection into bladder wall, other than a service associated with a service to which item 18375 or 18379 applies (H) (Anaes.) **Fee:** $251.80 **Benefit:** 75% = $188.85
Fee 36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) **Fee:** $510.75 **Benefit:** 75% = $383.10
Fee 36860	ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (Anaes.) **Fee:** $182.60 **Benefit:** 75% = $136.95 85% = $155.25
Fee 36863	Litholapaxy, with or without cystoscopy (Anaes.) **Fee:** $510.75 **Benefit:** 75% = $383.10
Fee 37000	BLADDER, partial excision of (Anaes.) (Assist.) (See para TN.8.157 of explanatory notes to this Category) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 37004	BLADDER, repair of rupture (Anaes.) (Assist.) **Fee:** $711.70 **Benefit:** 75% = $533.80
Fee 37008	Open cystostomy or cystotomy, suprapubic, other than: (a) a service to which item 37011 applies; or

	(b) a service associated with a service to which item 37245 applies; or (c) another open bladder procedure (Anaes.) (Assist.) **Fee:** $456.10 **Benefit:** 75% = $342.10 85% = $387.70
Fee 37011	Suprapubic stab cystotomy, other than a service associated with a service to which item 36827 applies (Anaes.) (See para TN.8.159 of explanatory notes to this Category) **Fee:** $102.20 **Benefit:** 75% = $76.65 85% = $86.90
Fee 37014	BLADDER, total excision of (Anaes.) (Assist.) (See para TN.8.157 of explanatory notes to this Category) **Fee:** $1,167.85 **Benefit:** 75% = $875.90
Fee 37015	Bladder, total excision of, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis (Anaes.) (Assist.) **Fee:** $1,401.40 **Benefit:** 75% = $1051.05
Fee 37016	Cystectomy, including prostatectomy and pelvic lymph node dissection, other than a service associated with a service to which items 37000, 37014, 37015, 37209, 35551 or 36502 applies (Anaes.) (Assist.) **Fee:** $2,185.20 **Benefit:** 75% = $1638.90
Fee 37018	Cystectomy, including prostatectomy and pelvic lymph node dissection, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis, other than a service associated with a service to which items 37000, 37014, 37015, 37016, 37209, 35551 or 36502 applies (Anaes.) (Assist.) **Fee:** $3,277.90 **Benefit:** 75% = $2458.45
Fee 37019	Cystectomy, including anterior exenteration and pelvic lymph node dissection, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502, and 35653 to 35756 apply (Anaes.) (Assist.) **Fee:** $2,182.75 **Benefit:** 75% = $1637.10
Fee 37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 37021	Cystectomy, including anterior exenteration and pelvic lymph node dissection, following previous open, laparoscopic or robot-assisted surgery, radiation therapy or chemotherapy to the pelvis, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502 and 35653 to 35756 apply (Anaes.) (Assist.) **Fee:** $3,274.05 **Benefit:** 75% = $2455.55
Fee 37023	VESICAL FISTULA, cutaneous, operation for (Anaes.) **Fee:** $456.10 **Benefit:** 75% = $342.10
Fee 37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) **Fee:** $456.10 **Benefit:** 75% = $342.10
Fee 37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60

Fee 37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.) **Fee:** $757.55 **Benefit:** 75% = $568.20
Fee 37039	Bladder stress incontinence, sling procedure for, using a non-autologous biological sling (Anaes.) (Assist.) **Fee:** $738.75 **Benefit:** 75% = $554.10
Fee 37040	Bladder stress incontinence, sling procedure for, using a non-adjustable synthetic male sling system, other than a service associated with a service to which item 37042 applies (H) (Anaes.) (Assist.) **Fee:** $998.10 **Benefit:** 75% = $748.60
Fee 37041	BLADDER ASPIRATION by needle **Fee:** $51.05 **Benefit:** 75% = $38.30 85% = $43.40
Fee 37042	Bladder stress incontinence—sling procedure for, using autologous fascial sling, including harvesting of sling, other than a service associated with a service to which item 35599 applies (H) (Anaes.) (Assist.) **Fee:** $998.10 **Benefit:** 75% = $748.60
Fee 37044	Bladder stress incontinence, suprapubic operation for (such as Burch colposuspension), open or laparoscopic route, using native tissue without graft, with diagnostic cystoscopy to assess the integrity of the lower urinary tract, not being a service associated with a service to which item 35599 or 36812 applies (H) (Anaes.) (Assist.) **Fee:** $848.90 **Benefit:** 75% = $636.70
Fee 37045	CONTINENT CATHETERISATION BLADDER STOMAS (eg. Mitrofanoff), formation of (Anaes.) (Assist.) **Fee:** $1,564.75 **Benefit:** 75% = $1173.60
Fee 37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) **Fee:** $1,824.70 **Benefit:** 75% = $1368.55
Fee 37048	Bladder neck closure for the management of urinary incontinence (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) **Fee:** $938.25 **Benefit:** 75% = $703.70
	OPERATIONS ON PROSTATE
Fee 37200	Prostatectomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.) (See para TN.8.162 of explanatory notes to this Category) **Fee:** $1,113.10 **Benefit:** 75% = $834.85
Fee 37201	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is, prostatectomy using diathermy or cold

	punch) and including services to which item 36854, 37203, 37206, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.) (See para TN.8.53 of explanatory notes to this Category) **Fee:** $907.80 **Benefit:** 75% = $680.85
Fee 37202	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy or cold punch) and including services to which item 36854, 37245, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203 or 37207 which had to be discontinued for medical reasons (Anaes.) (See para TN.8.53 of explanatory notes to this Category) **Fee:** $455.70 **Benefit:** 75% = $341.80 85% = $387.35
Fee 37203	Prostatectomy, transurethral resection using cautery, with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $1,141.35 **Benefit:** 75% = $856.05
Fee 37206	Prostatectomy, endoscopic, using diathermy or other ablative techniques: (a) with or without cystoscopy and with or without urethroscopy; and (b) including services to which one or more of items 36854, 37303, 37321 and 37324 apply; continuation, within 10 days, of treatment of benign prostatic hyperplasia that had to be discontinued for medical reasons (Anaes.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $611.30 **Benefit:** 75% = $458.50
Fee 37207	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37201, 37202, 37203, 37206, 37245, 37303, 37321 or 37324 applies (Anaes.) **Fee:** $1,141.35 **Benefit:** 75% = $856.05
Fee 37208	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by items 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (Anaes.) **Fee:** $611.30 **Benefit:** 75% = $458.50
Fee 37209	PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.) (Assist.) **Fee:** $1,414.10 **Benefit:** 75% = $1060.60
Fee 37210	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated) with or without bladder neck reconstruction, other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.) (See para TN.8.161 of explanatory notes to this Category) **Fee:** $1,745.20 **Benefit:** 75% = $1308.90

	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) with or without bladder neck reconstruction; and (b) with pelvic lymphadenectomy; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)
Fee 37211	(See para TN.8.161 of explanatory notes to this Category) **Fee:** $2,119.45 **Benefit:** 75% = $1589.60
	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) complicated by: (i) previous radiation therapy (including brachytherapy) on the prostate; or (ii) previous ablative procedures on the prostate; and (b) with bladder neck reconstruction; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)
Fee 37213	(See para TN.8.161 of explanatory notes to this Category) **Fee:** $2,617.60 **Benefit:** 75% = $1963.20
	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) complicated by: (i) previous radiation therapy (including brachytherapy) on the prostate; or (ii) previous ablative procedures on the prostate; and (b) with bladder neck reconstruction and pelvic lymphadenectomy; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)
Fee 37214	(See para TN.8.161 of explanatory notes to this Category) **Fee:** $3,179.50 **Benefit:** 75% = $2384.65
Fee 37215	Prostate, biopsy of, endoscopic, with or without cystoscopy (Anaes.) **Fee:** $456.10 **Benefit:** 75% = $342.10 85% = $387.70
	Prostate or prostatic bed, needle biopsy of, by the transrectal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55603 applies (Anaes.)
Fee 37216	(See para TN.8.160 of explanatory notes to this Category) **Fee:** $153.85 **Benefit:** 75% = $115.40 85% = $130.80

Fee 37217	Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed, under ultrasound guidance, being an item associated with a service to which item 55603 applies (Anaes.) (See para TN.8.54 of explanatory notes to this Category) **Fee:** $151.45 **Benefit:** 75% = $113.60 85% = $128.75
Fee 37218	Prostate, injection into, one or more, excluding insertion of fiduciary markers (Anaes.) (See para TN.8.54 of explanatory notes to this Category) **Fee:** $151.45 **Benefit:** 75% = $113.60 85% = $128.75
Fee 37219	Prostate or prostatic bed, needle biopsy of, by the transperineal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.) (See para TN.8.160 of explanatory notes to this Category) **Fee:** $369.20 **Benefit:** 75% = $276.90 85% = $313.85
Fee 37220	Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance: (a) for a patient with: (i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate); and (ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and (iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and (b) performed by a urologist at an approved site in association with a radiation oncologist; and (c) being a service associated with: (i) services to which items 15338 and 55603 apply; and (ii) a service to which item 60506 or 60509 applies (Anaes.) (See para TN.8.55 of explanatory notes to this Category) **Fee:** $1,143.65 **Benefit:** 75% = $857.75
Fee 37221	Prostatic abscess, endoscopic drainage of (Anaes.) **Fee:** $510.75 **Benefit:** 75% = $383.10
Fee 37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.) **Fee:** $225.90 **Benefit:** 75% = $169.45
Fee 37224	Prostate, diathermy or cauterisation, other than a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 37208 or 37215 applies (Anaes.) **Fee:** $354.00 **Benefit:** 75% = $265.50 85% = $300.90
Fee 37227	PROSTATE, transperineal insertion of catheters into, for high dose rate brachytherapy using ultrasound guidance including any associated cystoscopy. The procedure must be performed at an approved site in association with a radiation oncologist, and be associated with a service to which item 15331 or 15332 applies. (Anaes.) (See para TN.8.56 of explanatory notes to this Category) **Fee:** $619.70 **Benefit:** 75% = $464.80 85% = $526.75

Fee 37230	Prostate, ablation by electrocautery or high-energy transurethral microwave thermotherapy, with or without cystoscopy and with or without urethroscopy (Anaes.) (See para TN.8.163 of explanatory notes to this Category) **Fee:** $1,141.35 **Benefit:** 75% = $856.05 85% = $1048.15
Fee 37233	Prostate, ablation by electrocautery or high-energy transurethral microwave thermotherapy, with or without cystoscopy and with or without urethroscopy, continuation, within 10 days, of a urological procedure of the prostate that had to be discontinued for medical reasons (Anaes.) (See para TN.8.163 of explanatory notes to this Category) **Fee:** $611.30 **Benefit:** 75% = $458.50 85% = $519.65
Fee 37245	Prostate, endoscopic enucleation of, for the treatment of benign prostatic hyperplasia: (a) with morcellation, including mechanical morcellation or by an endoscopic technique; and (b) with or without cystoscopy; and (c) with or without urethroscopy; and other than a service associated with a service to which item 36827, 36854, 37008, 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) **Fee:** $1,382.35 **Benefit:** 75% = $1036.80
	OPERATIONS ON URETHRA, PENIS OR SCROTUM
Fee 37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.) **Fee:** $51.05 **Benefit:** 75% = $38.30 85% = $43.40
Fee 37303	URETHRAL STRICTURE, dilatation of (Anaes.) **Fee:** $81.15 **Benefit:** 75% = $60.90 85% = $69.00
Fee 37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.) **Fee:** $711.70 **Benefit:** 75% = $533.80
Fee 37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 37318	Urethroscopy, with or without cystoscopy, with one or more of biopsy, diathermy, visual laser destruction of urethral calculi or removal of foreign body or calculi (Anaes.) **Fee:** $302.95 **Benefit:** 75% = $227.25 85% = $257.55
Fee 37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes.) **Fee:** $102.20 **Benefit:** 75% = $76.65 85% = $86.90
Fee 37324	Urethrotomy or urethrostomy, internal or external (Anaes.) (Assist.) **Fee:** $251.80 **Benefit:** 75% = $188.85
Fee 37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) **Fee:** $354.00 **Benefit:** 75% = $265.50
Fee 37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) **Fee:** $711.70 **Benefit:** 75% = $533.80

Fee 37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $611.30 **Benefit:** 75% = $458.50
Fee 37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 37338	Urethral synthetic male sling system, division or removal of, for urethral obstruction, sling erosion, pain or infection, following previous surgery for urinary incontinence, other than a service associated with a service to which item 37340 or 37341 applies (Anaes.) (Assist.) **Fee:** $998.10 **Benefit:** 75% = $748.60
Fee 37339	Periurethral or transurethral injection of urethral bulking agents for the treatment of urinary incontinence, including cystoscopy and urethroscopy, other than a service associated with a service to which item 18375 or 18379 applies (Anaes.) **Fee:** $262.75 **Benefit:** 75% = $197.10 85% = $223.35
Fee 37340	Urethral synthetic sling, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, vaginal approach, other than a service associated with a service to which item 37341 or 37344 applies (Anaes.) (Assist.) **Fee:** $998.10 **Benefit:** 75% = $748.60
Fee 37341	Urethral sling, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, suprapubic, combined suprapubic and vaginal or combined suprapubic and perineal approach, other than a service associated with a service to which item 37340 or 37344 applies (Anaes.) (Assist.) **Fee:** $998.10 **Benefit:** 75% = $748.60
Fee 37342	URETHROPLASTY single stage operation (Anaes.) (Assist.) **Fee:** $912.45 **Benefit:** 75% = $684.35
Fee 37343	URETHROPLASTY, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.) (Assist.) **Fee:** $1,523.60 **Benefit:** 75% = $1142.70
Fee 37344	Urethral autologous fascial sling (or other biological sling), division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, vaginal approach, other than a service to which 37340 or 37341 applies (Anaes.) (Assist.) **Fee:** $998.10 **Benefit:** 75% = $748.60
Fee 37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.) **Fee:** $757.20 **Benefit:** 75% = $567.90
Fee 37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.) **Fee:** $757.20 **Benefit:** 75% = $567.90
Fee 37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $302.95 **Benefit:** 75% = $227.25
Fee 37354	HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.)

	Fee: $354.00 **Benefit:** 75% = $265.50
Fee 37369	URETHRA, excision of prolapse of (Anaes.) **Fee:** $204.40 **Benefit:** 75% = $153.30
Fee 37372	Urethral diverticulum, excision of (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) **Fee:** $1,268.15 **Benefit:** 75% = $951.15
Fee 37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) **Fee:** $1,268.15 **Benefit:** 75% = $951.15
Fee 37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) **Fee:** $354.00 **Benefit:** 75% = $265.50
Fee 37388	Artificial urinary sphincter, sterile, percutaneous adjustment of filling volume **Fee:** $107.30 **Benefit:** 75% = $80.50 85% = $91.25
Fee 37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 37393	PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.) **Fee:** $251.80 **Benefit:** 75% = $188.85 85% = $214.05
Fee 37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10
Fee 37402	PENIS, partial amputation of (Anaes.) (Assist.) **Fee:** $510.75 **Benefit:** 75% = $383.10
Fee 37405	PENIS, complete or radical amputation of (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) **Fee:** $510.75 **Benefit:** 75% = $383.10
Fee 37411	PENIS, repair of avulsion (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60 85% = $919.60

Fee 37415	Penis, injection of, for the investigation and treatment of erectile dysfunction. Applicable not more than twice in a 36-month period **Fee:** $51.05 **Benefit:** 75% = $38.30 85% = $43.40
Fee 37417	Penis, correction of chordee by plication techniques including Nesbit's corporoplasty (Anaes.) (Assist.) **Fee:** $611.30 **Benefit:** 75% = $458.50
Fee 37418	Penis, correction of chordee with incision or excision of fibrous plaque or plaques, with or without mobilisation of one or both of the neuro-vascular bundle and urethra (Anaes.) (Assist.) **Fee:** $812.10 **Benefit:** 75% = $609.10 85% = $718.90
Fee 37423	Penis, lengthening by translocation of corpora, in conjunction with partial penectomy or penile epispadias secondary repair, either as primary or secondary procedures (Anaes.) (Assist.) (See para TN.8.164 of explanatory notes to this Category) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) **Fee:** $1,067.35 **Benefit:** 75% = $800.55
Fee 37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) **Fee:** $354.00 **Benefit:** 75% = $265.50
Fee 37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) **Fee:** $1,012.80 **Benefit:** 75% = $759.60
Fee 37435	PENIS, frenuloplasty as an independent procedure (Anaes.) **Fee:** $102.20 **Benefit:** 75% = $76.65 85% = $86.90
Fee 37438	Scrotum, partial excision of, for histologically proven malignancy or infection (Anaes.) (Assist.) **Fee:** $302.95 **Benefit:** 75% = $227.25 85% = $257.55
	OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
Fee 37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.) **Fee:** $302.95 **Benefit:** 75% = $227.25 85% = $257.55
Fee 37604	Exploration of scrotal contents, with or without fixation and with or without biopsy, unilateral or bilateral, other than a service associated with sperm harvesting for IVF (Anaes.) **Fee:** $302.95 **Benefit:** 75% = $227.25 85% = $257.55
Fee 37605	Transcutaneous sperm retrieval, unilateral, from either the testis or the epididymis, for the purposes of intracytoplasmic sperm injection, for male factor infertility, excluding a service to which item 13218 applies. (Anaes.) (See para TN.8.58, TN.1.5 of explanatory notes to this Category) **Fee:** $409.00 **Benefit:** 75% = $306.75 85% = $347.65
Fee 37606	Open surgical sperm retrieval, unilateral, including the exploration of scrotal contents, with our without biopsy, for the purposes of intracytoplasmic sperm injection, for male factor infertility, performed in a hospital, excluding a service to which item 13218 or 37604 applies. (Anaes.) (See para TN.1.5, TN.8.59 of explanatory notes to this Category)

	Fee: $607.35 **Benefit:** 75% = $455.55 85% = $516.25
Fee 37607	Bilateral retroperitoneal lymph node dissection, for testicular tumour, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.165 of explanatory notes to this Category) **Fee:** $1,519.15 **Benefit:** 75% = $1139.40
Fee 37610	Bilateral retroperitoneal lymph node dissection, for testicular tumour, following previous similar retroperitoneal dissection, retroperitoneal radiation therapy or chemotherapy, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.165 of explanatory notes to this Category) **Fee:** $2,285.45 **Benefit:** 75% = $1714.10
Fee 37613	EPIDIDYMECTOMY (Anaes.) **Fee:** $302.95 **Benefit:** 75% = $227.25 85% = $257.55
Fee 37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $757.20 **Benefit:** 75% = $567.90
Fee 37619	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $302.95 **Benefit:** 75% = $227.25 85% = $257.55 **Extended Medicare Safety Net Cap:** $242.40
Fee 37623	VASOTOMY OR VASECTOMY, unilateral or bilateral NOTE: *Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim.* (Anaes.) (See para TN.8.46 of explanatory notes to this Category) **Fee:** $251.80 **Benefit:** 75% = $188.85 85% = $214.05
	PAEDIATRIC GENITURINARY SURGERY
Fee 37800	PATENT URACHUS, excision of, on a patient 10 years of age or over. (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 37801	PATENT URACHUS, excision of, when performed on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $742.25 **Benefit:** 75% = $556.70
Fee 37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies, on a patient 10 years of age or over. (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 37804	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37807 applies, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $742.25 **Benefit:** 75% = $556.70

Fee 37806	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $659.65 **Benefit:** 75% = $494.75 85% = $566.45
Fee 37807	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $857.55 **Benefit:** 75% = $643.20 85% = $764.35
Fee 37809	UNDESCENDED TESTIS, revision orchidopexy for, on a patient 10 years of age or over. (Anaes.) (Assist.) **Fee:** $659.65 **Benefit:** 75% = $494.75
Fee 37810	UNDESCENDED TESTIS, revision orchidopexy for, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $857.55 **Benefit:** 75% = $643.20
Fee 37812	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803, 37806 and 37809 applies, on a patient 10 years of age or over. (Anaes.) (Assist.) **Fee:** $608.90 **Benefit:** 75% = $456.70
Fee 37813	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37804, 37807 and 37810 applies, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $791.60 **Benefit:** 75% = $593.70
Fee 37815	HYPOSPADIAS, examination under anaesthesia with erection test on a patient 10 years of age or over. (Anaes.) **Fee:** $101.60 **Benefit:** 75% = $76.20
Fee 37816	HYPOSPADIAS, examination under anaesthesia with erection test, on a patient under 10 years of age (Anaes.) **Fee:** $132.10 **Benefit:** 75% = $99.10
Fee 37818	HYPOSPADIAS, glanuloplasty incorporating meatal advancement, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $538.25 **Benefit:** 75% = $403.70 85% = $457.55
Fee 37819	HYPOSPADIAS, glanuloplasty incorporating meatal advancement, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $699.75 **Benefit:** 75% = $524.85 85% = $606.55
Fee 37821	HYPOSPADIAS, distal, 1 stage repair, on a patient 10 years of age or over. (Anaes.) (Assist.) **Fee:** $912.45 **Benefit:** 75% = $684.35
Fee 37822	HYPOSPADIAS, distal, 1 stage repair, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $1,186.20 **Benefit:** 75% = $889.65
Fee 37824	HYPOSPADIAS, proximal, 1 stage repair, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $1,268.65 **Benefit:** 75% = $951.50
Fee 37825	HYPOSPADIAS, proximal, 1 stage repair, on a patient under 10 years of age (Anaes.) (Assist.)

T8. SURGICAL OPERATIONS	5. UROLOGICAL
	Fee: $1,649.20 **Benefit:** 75% = $1236.90
Fee 37827	HYPOSPADIAS, staged repair, first stage, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $584.45 **Benefit:** 75% = $438.35
Fee 37828	HYPOSPADIAS, staged repair, first stage, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $759.75 **Benefit:** 75% = $569.85
Fee 37830	HYPOSPADIAS, staged repair, second stage, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $757.20 **Benefit:** 75% = $567.90 85% = $664.00
Fee 37831	HYPOSPADIAS, staged repair, second stage, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $984.50 **Benefit:** 75% = $738.40 85% = $891.30
Fee 37833	Hypospadias, repair of urethral fistula, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $361.40 **Benefit:** 75% = $271.05
Fee 37834	Hypospadias, repair of urethral fistula, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $469.85 **Benefit:** 75% = $352.40
Fee 37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) **Fee:** $761.15 **Benefit:** 75% = $570.90
Fee 37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) **Fee:** $862.55 **Benefit:** 75% = $646.95
Fee 37842	Exstrophy of bladder or epispadias, primary or secondary repair with or without bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) **Fee:** $1,674.70 **Benefit:** 75% = $1256.05
Fee 37845	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty, with or without endoscopy (Anaes.) (Assist.) **Fee:** $761.15 **Benefit:** 75% = $570.90
Fee 37848	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) **Fee:** $1,370.15 **Benefit:** 75% = $1027.65
Fee 37851	Congenital disorder of sexual differentiation, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) **Fee:** $1,015.05 **Benefit:** 75% = $761.30
Fee 37854	Urethral valve, destruction of, including cystoscopy and urethroscopy (Anaes.) **Fee:** $401.35 **Benefit:** 75% = $301.05

T8. SURGICAL OPERATIONS	6. CARDIO-THORACIC
	Group T8. Surgical Operations
	Subgroup 6. Cardio-Thoracic

Fee 38426 S	Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) **Fee:** $496.50 **Benefit:** 75% = $372.40
	CARDIOLOGY PROCEDURES
Fee 38200	Right heart catheterisation with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurement by any method; (e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38254 or 38368 applies (Anaes.) (See para TN.8.220 of explanatory notes to this Category) **Fee:** $487.85 **Benefit:** 75% = $365.90 85% = $414.70
Fee 38203	Left heart catheterisation by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture, with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurements by any method; (e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38200, 38206, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (Anaes.) (See para TN.8.220 of explanatory notes to this Category) **Fee:** $582.20 **Benefit:** 75% = $436.65 85% = $494.90
Fee 38206	Right heart catheterisation with left heart catheterisation via the right heart or by another procedure, with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurements by any method;

	(e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38200, 38203, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (Anaes.) (See para TN.8.220 of explanatory notes to this Category) **Fee:** $703.85 **Benefit:** 75% = $527.90 85% = $610.65
Fee 38209	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $903.75 **Benefit:** 75% = $677.85 85% = $810.55
Fee 38212	Cardiac electrophysiological study for: (a) the investigation of supraventricular tachycardia involving 4 or more catheters; or (b) complex tachycardia inductions; or (c) multiple catheter mapping; or (d) acute intravenous anti-arrhythmic drug testing with pre and post drug inductions; or (e) catheter ablation to intentionally induce complete atrioventricular block; or (f) intraoperative mapping; other than a service associated with a service to which item 38209 or 38213 applies (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $1,503.15 **Benefit:** 75% = $1127.40 85% = $1409.95
Fee 38213	Cardiac electrophysiological study, performed either: (a) during insertion of implantable defibrillator; or (b) for defibrillation threshold testing at a different time to implantation; other than a service associated with a service to which item 38209 or 38212 applies (Anaes.) **Fee:** $447.65 **Benefit:** 75% = $335.75 85% = $380.55
Fee 38241	Use of a coronary pressure wire, if the service is: (a) performed during selective coronary angiography, percutaneous angioplasty or transluminal insertion of one or more stents; and (b) to measure fractional flow reserve, non-hyperaemic pressure ratios or coronary flow reserve in intermediate coronary artery or graft lesions (stenosis of 50 to 70%); and (c) to determine whether revascularisation is appropriate, if previous functional imaging:

	(i) has not been performed; or (ii) has been performed but the results are inconclusive or do not apply to the vessel being interrogated; and (d) performed on one or more coronary vascular territories (Anaes.) **Fee:** $514.35 **Benefit:** 75% = $385.80 85% = $437.20
Fee 38244	Note: (acute coronary syndrome) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Selective coronary angiography: (a) for a patient who is eligible for the service under clause 5.10.17A; and (b) with placement of one or more catheters and injection of opaque material into native coronary arteries; and (c) with or without left heart catheterisation, left ventriculography or aortography; and (d) including all associated imaging; other than a service associated with a service to which 38200, 38203, 38206, 38247, 38248, 38249, 38251 or 38252 applies (Anaes.) (See para TR.8.2, TR.8.5, TN.8.215 of explanatory notes to this Category) **Fee:** $968.35 **Benefit:** 75% = $726.30 85% = $875.15
Fee 38247	Note: (acute coronary syndrome - graft) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Selective coronary and graft angiography: (a) for a patient who is eligible for the service under clause 5.10.17A; and (b) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and (c) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present—with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38248, 38249, 38251 or 38252 applies (Anaes.) (See para TR.8.2, TR.8.5, TN.8.215, TN.8.216 of explanatory notes to this Category) **Fee:** $1,551.45 **Benefit:** 75% = $1163.60 85% = $1458.25
Fee 38248	Note: (stable coronary syndrome) the service only applies if the patient meets the requirements of the descriptor and the of Note: TR.8.3 and TR.8.5

	Selective coronary angiography: (a) for a patient who is eligible for the service under clause 5.10.17B; and (b) as part of the management of the patient; and (c) with placement of catheters and injection of opaque material into native coronary arteries; and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38249, 38251 or 38252 applies—applicable each 3 months (Anaes.) (See para TR.8.3, TR.8.5, TR.8.6, TN.8.215 of explanatory notes to this Category) **Fee:** $968.35 **Benefit:** 75% = $726.30 85% = $875.15
Fee 38249	Note: (stable coronary syndrome - graft) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.3 and TR.8.5 Selective coronary and graft angiography: (a) for a patient who is eligible for the service under clause 5.10.17B; and (b) as part of the management of the patient; and (c) with placement of one or more catheters and injection of opaque material into native coronary arteries; and (d) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present—with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (e) with or without left heart catheterisation, left ventriculography or aortography; and (f) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38251 or 38252 applies—applicable once each 3 months (Anaes.) (See para TR.8.3, TR.8.5, TR.8.6, TN.8.215, TN.8.216 of explanatory notes to this Category) **Fee:** $1,551.45 **Benefit:** 75% = $1163.60 85% = $1458.25
Fee 38251	Note: (pre-operative assessment) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.5 Selective coronary angiography: (a) for a symptomatic patient with valvular or other non-coronary structural heart disease; and (b) as part of the management of the patient for: (i) pre-operative assessment for planning non-coronary cardiac surgery, including by transcatheter approaches; or

	(ii) evaluation of valvular heart disease or other non-coronary structural heart disease where clinical impression is discordant with non-invasive assessment; and (c) with placement of catheters and injection of opaque material into native coronary arteries; and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249 or 38252 applies—applicable once each 12 months (Anaes.) (See para TR.8.5, TN.8.215 of explanatory notes to this Category) **Fee:** $968.35 **Benefit:** 75% = $726.30 85% = $875.15
Fee 38252	Note: (pre-operative assessment - graft) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.5 Selective coronary and graft angiography: (a) for a symptomatic patient with valvular or other non-coronary structural heart disease; and (b) as part of the management of the patient for: (i) pre-operative assessment for planning non-coronary cardiac surgery, including by transcatheter approaches; or (ii) evaluation of valvular heart disease or other non-coronary structural heart disease where clinical impression is discordant with non-invasive assessment; and (c) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and (d) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present—with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (e) with or without left heart catheterisation, left ventriculography or aortography; and (f) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249 or 38251 applies—applicable once each 12 months (Anaes.) (See para TR.8.5, TN.8.215, TN.8.216 of explanatory notes to this Category) **Fee:** $1,551.45 **Benefit:** 75% = $1163.60 85% = $1458.25
Fee 38254	Right heart catheterisation: (a) performed at the same time as a service to which item 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313 or 38314 applies; and (b) including any of the following (if performed): (i) fluoroscopy; (ii) oximetry;

	(iii) dye dilution curves; (iv) cardiac output measurement; (v) shunt detection; (vi) exercise stress test (Anaes.) **Fee:** $487.85 **Benefit:** 75% = $365.90 85% = $414.70
Fee 38256	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes.) **Fee:** $292.70 **Benefit:** 75% = $219.55 85% = $248.80
Fee 38270	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.) (See para TN.8.278 of explanatory notes to this Category) **Fee:** $999.15 **Benefit:** 75% = $749.40 85% = $905.95
Fee 38272	Atrial septal defect or patent foramen closure: (a) for congenital heart disease in a patient with documented evidence of right heart overload or paradoxical embolism; and (b) using a septal occluder or similar device, by transcatheter approach; and (c) including right or left heart catheterisation (or both); other than a service associated with a service to which item 38200, 38203, 38206 or 38254 applies (Anaes.) (Assist.) (See para TN.8.221 of explanatory notes to this Category) **Fee:** $999.15 **Benefit:** 75% = $749.40 85% = $905.95
Fee 38273	Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (Anaes.) (Assist.) **Fee:** $999.15 **Benefit:** 75% = $749.40
Fee 38274	Ventricular septal defect, transcatheter closure of, with cardiac catheterisation, excluding imaging (H) (Anaes.) (Assist.) **Fee:** $818.50 **Benefit:** 75% = $613.90
Fee 38275	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.) **Fee:** $326.55 **Benefit:** 75% = $244.95 85% = $277.60
Fee 38276 S	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, if: (a) the patient is at increased risk of thromboembolism demonstrated by: (i) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non-central nervous system systemic embolism; or

	(ii) at least 2 of the following risk factors: (A) an age of 65 years or more; (B) hypertension; (C) diabetes mellitus; (D) heart failure or left ventricular ejection fraction of 35% or less (or both); (E) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque); and (b) the patient has an absolute and permanent contraindication to oral anticoagulation (confirmed by written documentation that is provided by a medical practitioner, independent of the practitioner rendering the service); and (c) the service is not associated with a service to which item 38200, 38203, 38206 or 38254 applies (H) (Anaes.) (Assist.) (See para TN.8.132 of explanatory notes to this Category) **Fee:** $999.15 **Benefit:** 75% = $749.40
Fee 38285	Insertion of implantable ECG loop recorder, by a specialist or consultant physician, for the diagnosis of a primary disorder, including initial programming and testing, if: (a) the patient has recurrent unexplained syncope and does not have a structural heart defect associated with a high risk of sudden cardiac death; and (b) a diagnosis has not been achieved through all other available cardiac investigations; and (c) a neurogenic cause is not suspected (Anaes.) (See para TN.8.61, TN.8.211 of explanatory notes to this Category) **Fee:** $168.95 **Benefit:** 75% = $126.75 85% = $143.65
Fee 38286	Removal of implantable ECG loop recorder (Anaes.) (See para TN.8.211 of explanatory notes to this Category) **Fee:** $152.20 **Benefit:** 75% = $114.15 85% = $129.40
Fee 38288	Implantable loop recorder, insertion of, for diagnosis of atrial fibrillation, if: (a) the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source; and (b) the bases of the diagnosis included the following: (i) the medical history of the patient; (ii) physical examination; (iii) brain and carotid imaging; (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:** $211.30 **Benefit:** 75% = $158.50 85% = $179.65
	CATHETER BASED ARRHYTHMIA ABLATION
Fee 38287	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.) **Fee:** $2,298.35 **Benefit:** 75% = $1723.80 85% = $2205.15
Fee 38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.) **Fee:** $2,926.40 **Benefit:** 75% = $2194.80
Fee 38293	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.) **Fee:** $3,141.15 **Benefit:** 75% = $2355.90 85% = $3047.95
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
Fee 38307	Note: (acute coronary syndrome - 1 coronary territory with selective coronary angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and

	(e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) (See para TN.8.217, TN.8.225, TR.8.2, TR.8.5 of explanatory notes to this Category) **Fee:** $1,941.55 **Benefit:** 75% = $1456.20 85% = $1848.35
Fee 38308	Note: (acute coronary syndrome - 2 coronary territories with selective coronary angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) (See para TN.8.217, TN.8.225, TR.8.2, TR.8.5 of explanatory notes to this Category) **Fee:** $2,233.80 **Benefit:** 75% = $1675.35 85% = $2140.60
Fee 38309	Percutaneous transluminal rotational atherectomy of one or more coronary arteries, including all associated imaging, if: (a) the target stenosis within at least one coronary artery is heavily calcified and balloon angioplasty with or without stenting is not feasible without rotational artherectomy; and (b) the service is performed in conjunction with a service to which item 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies Applicable only once on each occasion the service is performed (Anaes.) (Assist.) (See para TN.8.222 of explanatory notes to this Category) **Fee:** $1,316.45 **Benefit:** 75% = $987.35 85% = $1223.25

	Note: (acute coronary syndrome - 3 coronary territories with selective coronary angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)
Fee 38310	(See para TN.8.217, TN.8.225, TR.8.2, TR.8.5 of explanatory notes to this Category) **Fee:** $2,526.10 **Benefit:** 75% = $1894.60 85% = $2432.90
	Note: (stable multi-vessel disease - 1 coronary territory with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38314 applies; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and
Fee 38311	(e) excluding aftercare;

	other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) (See para TR.8.4, TR.8.5, TN.8.226, TR.8.6, TN.8.218 of explanatory notes to this Category) **Fee:** $1,941.55 **Benefit:** 75% = $1456.20 85% = $1848.35
Fee 38313	Note: (stable multi-vessel disease - 2 coronary territories with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38314 applies; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) (See para TR.8.4, TR.8.5, TN.8.226, TR.8.6, TN.8.218 of explanatory notes to this Category) **Fee:** $2,233.80 **Benefit:** 75% = $1675.35 85% = $2140.60
Fee 38314	Note: (stable multi-vessel disease - 3 coronary territory with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17C; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and

	(ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) (See para TR.8.4, TR.8.5, TN.8.226, TR.8.7, TN.8.218, TN.8.219 of explanatory notes to this Category) **Fee:** $2,526.10 **Benefit:** 75% = $1894.60 85% = $2432.90
Fee 38316	Note: (acute coronary syndrome - 1 coronary territory without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) (See para TN.8.217, TN.8.225, TR.8.2, TR.8.5 of explanatory notes to this Category) **Fee:** $1,735.65 **Benefit:** 75% = $1301.75 85% = $1642.45
Fee 38317	Note: (acute coronary syndrome - 2 coronary territories without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and

	(c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 3808, 38310, 38311, 38313, 38314, 38316, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) (See para TN.8.217, TN.8.225, TR.8.2, TR.8.5 of explanatory notes to this Category) **Fee:** $2,198.60 **Benefit:** 75% = $1648.95 85% = $2105.40
Fee 38319	Note: (acute coronary syndrome - 3 coronary territories without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38320, 38322 or 38323 applies (Anaes.) (Assist.) (See para TN.8.217, TN.8.225, TR.8.2, TR.8.5 of explanatory notes to this Category) **Fee:** $2,490.85 **Benefit:** 75% = $1868.15 85% = $2397.65
Fee 38320	Note: (stable multi-vessel disease - 1 coronary territory without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38323 applies; and

	(ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38322 or 38323 applies (Anaes.) (Assist.) (See para TR.8.4, TR.8.5, TN.8.226, TR.8.6, TN.8.218 of explanatory notes to this Category) **Fee:** $1,735.65 **Benefit:** 75% = $1301.75 85% = $1642.45
Fee 38322	Note: (stable multi-vessel disease - 2 coronary territories with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38323 applies; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38323 applies (Anaes.) (Assist.) (See para TR.8.4, TR.8.5, TN.8.226, TR.8.6, TN.8.218 of explanatory notes to this Category) **Fee:** $2,198.60 **Benefit:** 75% = $1648.95 85% = $2105.40
Fee 38323	Note: (stable multi-vessel disease - 3 coronary territories with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention:

	(a) for a patient: (i) eligible for the service under clause 5.10.17C; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38322 applies (Anaes.) (Assist.) (See para TR.8.4, TR.8.5, TN.8.226, TR.8.7, TN.8.218, TN.8.219 of explanatory notes to this Category) **Fee:** $2,490.85 **Benefit:** 75% = $1868.15 85% = $2397.65
	MISCELLANEOUS CARDIAC PROCEDURES
Fee 38350	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $699.50 **Benefit:** 75% = $524.65
Fee 38353	PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $279.75 **Benefit:** 75% = $209.85
Fee 38356	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $917.05 **Benefit:** 75% = $687.80
Fee 38358	Extraction of one or more chronically implanted transvenous pacing or defibrillator leads, by percutaneous method, with locking stylets and snares, with extraction sheaths (if any), if: (a) the leads have been in place for more than 6 months and require removal; and (b) the service is performed: (i) in association with a service to which item 61109 or 60509 applies; and (ii) by a specialist or consultant physician who has undertaken the training to perform the service; and

	(iii) in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and (c) if the service is performed by an interventional cardiologist—a cardiothoracic surgeon is in attendance during the service (H) (Anaes.) (Assist.) (See para TN.8.64, TN.8.214 of explanatory notes to this Category) **Fee:** $3,141.15 **Benefit:** 75% = $2355.90
Fee 38359	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.) **Fee:** $146.30 **Benefit:** 75% = $109.75 85% = $124.40
Fee 38362	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.) **Fee:** $421.55 **Benefit:** 75% = $316.20 85% = $358.35
Fee 38365	Insertion, removal or replacement of permanent cardiac synchronisation device, if the patient: (a) has all of the following: (i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 130 ms; or (b) has all of the following: (i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 150 ms; other than a service associated with a service to which item 38212 applies (H) (Anaes.) (Assist.) (See para TN.8.63 of explanatory notes to this Category) **Fee:** $279.75 **Benefit:** 75% = $209.85
Fee 38368	Insertion, removal or replacement of permanent transvenous left ventricular electrode, through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venograms, if the patient: (a) has all of the following: (i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 130 ms; or (b) has all of the following:

	(i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 150 ms; other than a service associated with a service to which item 35200, 38200 or 38212 applies (H) (Anaes.) (Assist.) (See para TN.8.63 of explanatory notes to this Category) **Fee:** $1,341.20 **Benefit:** 75% = $1005.90
Fee 38471	Insertion of implantable defibrillator, including insertion of patches for the insertion of one or more transvenous endocardial leads, if the patient has one of the following: (a) a history of haemodynamically significant ventricular arrhythmias in the presence of structural heart disease; (b) documented high-risk genetic cardiac disease; (c) ischaemic heart disease, with a left ventricular ejection fraction of less than 30% at least one month after experiencing a myocardial infarction and while on optimised medical therapy; (d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricular ejection fraction of less than 35% (despite optimised medical therapy); other than a service to which item 38212 applies (H) (Anaes.) (Assist.) **Fee:** $1,152.85 **Benefit:** 75% = $864.65
Fee 38472	Insertion, replacement or removal of implantable defibrillator generator, if the patient has one of the following: (a) a history of haemodynamically significant ventricular arrhythmias in the presence of structural heart disease; (b) documented high-risk genetic cardiac disease; (c) ischaemic heart disease, with a left ventricular ejection fraction of less than 30% at least one month after experiencing a myocardial infarction and while on optimised medical therapy; (d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricular ejection fraction of less than 35% (despite optimised medical therapy); other than a service to which item 38212 applies (H) (Anaes.) (Assist.) **Fee:** $315.25 **Benefit:** 75% = $236.45
	THORACIC SURGERY
Fee 38416 S	Endoscopic ultrasound guided fine needle aspiration biopsy or biopsies (endoscopy with ultrasound imaging) to obtain one or more specimens from either or both of the following: (a) mediastinal masses; (b) locoregional nodes to stage non-small cell lung carcinoma;

	other than a service associated with a service to which an item in Subgroup 1 of this Group, or item 38417 or 55054, applies (Anaes.) (See para TN.8.21 of explanatory notes to this Category) **Fee:** $617.00 **Benefit:** 75% = $462.75 85% = $524.45
Fee 38417 S	Endobronchial ultrasound guided biopsy or biopsies (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by: (a) transbronchial biopsy or biopsies of peripheral lung lesions; or (b) fine needle aspirations of one or more mediastinal masses; or (c) fine needle aspirations of locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with a service to which an item in Subgroup 1 of this Group, item 38416, 38420 or 38423, or an item in Subgroup I5 of Group I3, applies (Anaes.) (See para TN.8.21 of explanatory notes to this Category) **Fee:** $617.00 **Benefit:** 75% = $462.75 85% = $524.45
Fee 38419 S	Bronchoscopy, as an independent procedure (Anaes.) **Fee:** $195.00 **Benefit:** 75% = $146.25 85% = $165.75
Fee 38420 S	Bronchoscopy with one or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) **Fee:** $257.45 **Benefit:** 75% = $193.10 85% = $218.85
Fee 38422 S	Bronchus, removal of foreign body in (Anaes.) (Assist.) **Fee:** $402.75 **Benefit:** 75% = $302.10
Fee 38423 S	Fibreoptic bronchoscopy with one or more transbronchial lung biopsies, with or without bronchial or broncho-alveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.) **Fee:** $281.45 **Benefit:** 75% = $211.10 85% = $239.25
Fee 38425 S	Endoscopic laser resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $661.80 **Benefit:** 75% = $496.35
Fee 38428 S	Bronchoscopy with treatment of tracheal stricture (Anaes.) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $229.50
Fee 38429	Tracheal excision and repair of, without cardiopulmonary bypass (H) (Anaes.) (Assist.) **Fee:** $1,884.80 **Benefit:** 75% = $1413.60
Fee 38431	Tracheal excision and repair of, with cardiopulmonary bypass (H) (Anaes.) (Assist.) **Fee:** $2,549.35 **Benefit:** 75% = $1912.05

Fee 38815	Thoracoscopy, with or without division of pleural adhesions, with or without biopsy, including insertion of intercostal catheter where necessary, other than a service associated with a service to which item 18258, 18260, 38816 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $273.50 **Benefit:** 75% = $205.15
Fee 38816 S	Thoracotomy, exploratory, with or without biopsy, including insertion of an intercostal catheter where necessary, other than a service associated with a service to which item 18258, 18260, 38815 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $1,049.70 **Benefit:** 75% = $787.30
Fee 38817 S	Thoracotomy, thoracoscopy or sternotomy, by any procedure: (a) including any division of adhesions if the time taken to divide the adhesions exceeds 30 minutes; and (b) other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18258, 18260, 33824, 38815, 38816, 38818, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,650.10 **Benefit:** 75% = $1237.60
Fee 38818 S	Thoracotomy, thoracoscopy or median sternotomy for post operative bleeding, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18258, 18260, 33824, 38815, 38816, 38817, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $1,049.70 **Benefit:** 75% = $787.30
Fee 38820 S	Lung, wedge resection of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38820, 38821 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $1,256.45 **Benefit:** 75% = $942.35
Fee 38821	Lung, wedge resection of, 2 or more wedges, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38820 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $1,884.70 **Benefit:** 75% = $1413.55
Fee 38822	Pneumonectomy, lobectomy, bilobectomy or segmentectomy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38823, 38824 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $1,677.85 **Benefit:** 75% = $1258.40

Fee 38823	Radical lobectomy, pneumonectomy, bilobectomy, segmentectomy or formal mediastinal node dissection (greater than 4 nodes), other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38822, 38824 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $2,073.15 **Benefit:** 75% = $1554.90
Fee 38824	Segmentectomy, lobectomy, bilobectomy or pneumonectomy, including resection of chest wall, diaphragm, pericardium, and formal mediastinal node dissection (greater than 4 nodes), other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38822, 38823 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $2,591.40 **Benefit:** 75% = $1943.55
Fee 38828	Intercostal drain, insertion of: (a) not involving resection of rib; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 38815, 38816, 38829, 38830, 38831, 38832, 38833 or 38834 applies (Anaes.) **Fee:** $146.30 **Benefit:** 75% = $109.75 85% = $124.40
Fee 38829	Intercostal drain, insertion of, with pleurodesis: (a) not involving resection of rib; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 38815, 38816, 38828, 38830, 38831, 38832, 38833 or 38834 applies (Anaes.) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
Fee 38830	Empyema, radical operation for, involving resection of rib, other than a service associated with a service to which item 38828, 38829, 38831, 38832, 38833 or 38834 applies (H) (Anaes.) (Assist.) **Fee:** $437.40 **Benefit:** 75% = $328.05
Fee 38831	Thoracoscopy or thoracotomy and drainage of paraneumonic effusion and empyema, exploratory, with or without biopsy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38832, 38833 or 38834 applies (H) (Anaes.) (Assist.) **Fee:** $1,574.50 **Benefit:** 75% = $1180.90

Fee 38832	Thoracotomy or thoracoscopy, with pulmonary decortication, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38833 or 38834 applies (H) (Anaes.) (Assist.) **Fee:** $1,677.85 **Benefit:** 75% = $1258.40
Fee 38833	Thoracotomy or thoracoscopy, with pleurectomy or pleurodesis, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38832 or 38834 applies (H) (Anaes.) (Assist.) **Fee:** $1,049.70 **Benefit:** 75% = $787.30
Fee 38834	Thoracotomy and radical extra pleural pneumonectomy or radical lung preserving decortication and pleurectomy for malignancy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38832 or 38833 applies (H) (Anaes.) (Assist.) **Fee:** $3,887.20 **Benefit:** 75% = $2915.40
Fee 38837	Mediastinum, cervical exploration of, with or without biopsy, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $397.60 **Benefit:** 75% = $298.20
Fee 38838	Thoracotomy or thoracoscopy or sternotomy, for removal of thymus or mediastinal tumour, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $1,296.15 **Benefit:** 75% = $972.15
Fee 38839	Pericardium, subxiphoid open surgical drainage of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38840 applies (H) (Anaes.) (Assist.) **Fee:** $628.35 **Benefit:** 75% = $471.30
Fee 38840	Pericardium, transthoracic (thoracotomy or thoracoscopy) open surgical drainage of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38839 applies (H) (Anaes.) (Assist.) **Fee:** $938.20 **Benefit:** 75% = $703.65
Fee 38841	Pericardiectomy via sternotomy or thoracoscopy or anterolateral thoracotomy without cardiopulmonary bypass, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $1,677.85 **Benefit:** 75% = $1258.40

Fee 38842	Pericardiectomy via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $2,347.30 **Benefit:** 75% = $1760.50
Fee 38845	Sternal wire or wires, removal of, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) **Fee:** $301.65 **Benefit:** 75% = $226.25
Fee 38846	Pectus excavatum or pectus carinatum, repair or radical correction of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38847, 38848 or 38849 applies (H) (Anaes.) (Assist.) (See para TN.8.259 of explanatory notes to this Category) **Fee:** $1,566.45 **Benefit:** 75% = $1174.85
Fee 38847	Pectus excavatum, repair of, with implantation of subcutaneous prosthesis, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846, 38848 or 38849 applies (H) (Anaes.) (Assist.) **Fee:** $834.95 **Benefit:** 75% = $626.25
Fee 38848	Pectus excavatum, repair of, with insertion of a concave bar, by any method, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846 or 38847 applies (H) (Anaes.) (Assist.) **Fee:** $1,253.15 **Benefit:** 75% = $939.90
Fee 38849	Pectus excavatum, removal of a concave bar, by any method, not being a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846 or 38847 applies (H) (Anaes.) (Assist.) **Fee:** $626.50 **Benefit:** 75% = $469.90
Fee 38850	Sternotomy wound, debridement of, not involving reopening of the mediastinum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38851 applies (H) (Anaes.) **Fee:** $357.50 **Benefit:** 75% = $268.15
Fee 38851	Sternotomy wound, debridement of, involving curettage of infected bone, with or without removal of wires, but not involving reopening of the mediastinum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38850 applies (H) (Anaes.) **Fee:** $388.60 **Benefit:** 75% = $291.45

Fee 38852	Sternum, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38853 applies (H) (Anaes.) (Assist.) **Fee:** $1,049.25 **Benefit:** 75% = $786.95
Fee 38853	Sternum and mediastinum, reoperation for infection of, involving muscle advancement flaps and/or greater omentum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38852 applies (H) (Anaes.) (Assist.) **Fee:** $1,644.95 **Benefit:** 75% = $1233.75
Fee 38857	Chest wall resection, sternum and/or ribs without reconstruction, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38824, 38828 or 38858 applies (H) (Anaes.) (Assist.) **Fee:** $1,988.05 **Benefit:** 75% = $1491.05
Fee 38858	Chest wall resection, sternum and / or ribs with reconstruction, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38824, 38828 or 38857 applies (H) (Anaes.) (Assist.) **Fee:** $2,591.40 **Benefit:** 75% = $1943.55
Fee 38859	Plating of multiple ribs for flail segment, other than a service associated with a service to which item 18258, 18260, 33815, 38816 or 38828 applies (H) (Anaes.) (Assist.) (See para TN.8.260 of explanatory notes to this Category) **Fee:** $1,049.70 **Benefit:** 75% = $787.30
Fee 38864	Intrathoracic operations on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than one of those organs, not being a service to which another item in this Group applies, other than a service associated with a service to which item 18258, 18260 or 38828 applies (H) (Anaes.) (Assist.) **Fee:** $1,677.85 **Benefit:** 75% = $1258.40
	CARDIAC SURGERY PROCEDURES
Fee 38467	Insertion, removal or replacement of permanent myocardial electrode, by open surgical approach, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $1,049.70 **Benefit:** 75% = $787.30
	VALVULAR PROCEDURES

Fee 38461	TMVr, by transvenous or transeptal techniques, for permanent coaptation of mitral valve leaflets using one or more Mitraclips™, including intra-operative diagnostic imaging, if: (a) the patient has each of the following risk factors: (i) moderate to severe, or severe, symptomatic degenerative (primary) mitral valve regurgitation (grade 3+ or 4+); (ii) left ventricular ejection fraction of 20% or more; (iii) symptoms of mild, moderate or severe chronic heart failure (New York Heart Association class II, III or IV); and (b) as a result of a TMVr suitability case conference, the patient has been: (i) assessed as having an unacceptably high risk for surgical mitral valve replacement; and (ii) recommended as being suitable for the service; and (c) the service is performed: (i) by a cardiothoracic surgeon, or an interventional cardiologist, accredited by the TMVr accreditation committee to perform the service; and (ii) via transfemoral venous delivery, unless transfemoral venous delivery is contraindicated or not feasible; and (iii) in a hospital that is accredited by the TMVr accreditation committee as a suitable hospital for the service; and (d) a service to which this item, or item 38463, applies has not been provided to the patient in the previous 5 years (H) (Anaes.) (Assist.) **Fee:** $1,568.60 **Benefit:** 75% = $1176.45
Fee 38463	TMVr, by transvenous or transeptal techniques, for permanent coaptation of mitral valve leaflets using one or more Mitraclips™, including intra-operative diagnostic imaging, if: (a) the patient has each of the following risk factors: (i) moderate to severe, or severe, symptomatic functional (secondary) mitral valve regurgitation (grade 3+ or 4+); (ii) left ventricular ejection fraction of 20% to 50%; (iii) left ventricular end systolic diameter of not more than 70mm; (iv) symptoms of mild, moderate or severe chronic heart failure (New York Heart Association class II, III or IV) that persist despite maximally tolerated guideline directed medical therapy; and (b) as a result of a TMVr suitability case conference, the patient has been: (i) assessed as having an unacceptably high risk for surgical mitral valve replacement; and

	(ii) recommended as being suitable for the service; and (c) the service is performed: (i) by a cardiothoracic surgeon, or an interventional cardiologist, accredited by the TMVr accreditation committee to perform the service; and (ii) via transfemoral venous delivery, unless transfemoral venous delivery is contraindicated or not feasible; and (iii) in a hospital that is accredited by the TMVr accreditation committee as a suitable hospital for the service; and (d) a service to which this item, or item 38461, applies has not been provided to the patient in the previous 5 years (H) (Anaes.) (Assist.) **Fee:** $1,568.60 **Benefit:** 75% = $1176.45
Fee 38477	Valve annuloplasty with insertion of ring, other than: (a) a service to which item 38516 or 38517 applies; or (b) a service associated with a service to which to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67, TN.8.213 of explanatory notes to this Category) **Fee:** $2,194.15 **Benefit:** 75% = $1645.65
Fee 38484	Aortic or pulmonary valve replacement with bioprosthesis or mechanical prosthesis, including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $2,223.25 **Benefit:** 75% = $1667.45
Fee 38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $894.90 **Benefit:** 75% = $671.20
Fee 38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,884.80 **Benefit:** 75% = $1413.60
Fee 38490	Reconstruction and re-implantation of sub-valvular structures, if performed in conjunction with a service to which item 38499 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $607.35 **Benefit:** 75% = $455.55
Fee 38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,144.00 **Benefit:** 75% = $1608.00

	TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: a. the TAVI patient is at high risk for surgery; and b. the service: (i) is performed by a TAVI Practitioner in a TAVI Hospital ; and (ii) includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; not being a service which has been rendered within 5 years of a service to which this item or item 38514 or 38522 applies (H) (Anaes.) (Assist.)
Fee 38495	(See para AN.33.1, TN.8.135, TN.8.278 of explanatory notes to this Category) **Fee:** $1,568.60 **Benefit:** 75% = $1176.45
	Mitral or tricuspid valve replacement with bioprothesis or mechanical prosthesis, including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38499	**Fee:** $2,223.25 **Benefit:** 75% = $1667.45
	TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: a. the TAVI patient is at intermediate risk for surgery; and b. the service: i. is performed by a TAVI practitioner in a TAVI Hospital; and ii. includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; not being a service which has been rendered within 5 years of a service to which this item or item 38495 or 38522 applies (H) (Anaes.) (Assist.)
Fee 38514 S	(See para TN.8.135, AN.33.1, TN.8.278 of explanatory notes to this Category) **Fee:** $1,568.60 **Benefit:** 75% = $1176.45
	Simple valve repair: (a) with or without annuloplasty; and (b) including quadrangular resection, cleft closure or alfieri; and (c) including retrograde cardioplegia (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38516	**Fee:** $2,736.70 **Benefit:** 75% = $2052.55
	Complex valve repair: (a) with or without annuloplasty; and
Fee 38517	(b) including retrograde cardioplegia (if performed); and

	(c) including one of the following: (i) neochords; (ii) chordal transfer; (iii) patch augmentation; (iv) multiple leaflets; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $3,368.25 **Benefit:** 75% = $2526.20
Fee 38519	Valve explant of a previous prosthesis, if performed during open cardiac surgery, not being a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $1,157.85 **Benefit:** 75% = $868.40
Fee 38522 S	TAVI, for the treatment of symptomatic severe native calcific aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: a. the TAVI Patient is at low risk for surgery; and b. the service: i. is performed by a TAVI Practitioner in a TAVI Hospital; and ii. includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; not being a service which has been rendered within 5 years of a service to which this item or item 38495 or 38514 applies (H) (Anaes.) (Assist.) (See para AN.33.1, TN.8.135, TN.8.278 of explanatory notes to this Category) **Fee:** $1,568.60 **Benefit:** 75% = $1176.45
Fee 38523 S	Percutaneous transcatheter delivery of dual-filter cerebral embolic protection system during a TAVI procedure, for the reduction of postoperative embolic ischaemic strokes, if: a. the service is performed upon a TAVI Patient in a TAVI Hospital; and b. where the service is performed by the practitioner performing the TAVI procedure, the service includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient (H) (Anaes.) (Assist.) **Fee:** $285.10 **Benefit:** 75% = $213.85
	SURGERY FOR ISCHAEMIC HEART DISEASE
Fee 38502	Coronary artery bypass, including cardiopulmonary bypass, with or without retrograde cardioplegia, with or without vein grafts, and including at least one of the following: (a) harvesting of left internal mammary artery and vein graft material; (b) harvesting of left internal mammary artery;

	(c) harvesting of vein graft material; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $2,580.40 **Benefit:** 75% = $1935.30
Fee 38508	Repair or reconstruction of left ventricular aneurysm, including plication, resection and primary and patch repairs, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,101.15 **Benefit:** 75% = $1575.90
Fee 38509	Repair of ischaemic ventricular septal rupture,, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,616.10 **Benefit:** 75% = $1962.10
Fee 38510	Artery harvesting (other than of the left internal mammary), for coronary artery bypass, if: (a) more than one arterial graft is required; and (b) the service is performed in conjunction with coronary artery bypass surgery performed by any medical practitioner (H) (Anaes.) (Assist.) **Fee:** $683.40 **Benefit:** 75% = $512.55
Fee 38511	Coronary artery bypass, with the aid of tissue stabilisers, if the service is performed: (a) without cardiopulmonary bypass; and (b) in conjunction with a service to which item 38502 applies (H) (Anaes.) (Assist.) **Fee:** $657.15 **Benefit:** 75% = $492.90
Fee 38513	Creation of Y-graft, T-graft and graft-to-graft extensions, with micro-arterial or micro-venous anastomosis using microsurgical techniques, if: (a) the service is for one or more anastomoses; and (b) the service is performed in conjunction with a service to which item 38502 applies (H) (Anaes.) (Assist.) **Fee:** $1,095.25 **Benefit:** 75% = $821.45
	ARRHYTHMIA SURGERY
Fee 38512	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving one atrial chamber only, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,298.35 **Benefit:** 75% = $1723.80

	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38515	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,926.40 **Benefit:** 75% = $2194.80
	Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38518	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,141.15 **Benefit:** 75% = $2355.90
	PROCEDURES ON THORACIC AORTA
	Repair or replacement of ascending thoracic aorta: (a) including: (i) cardiopulmonary bypass; and (ii) retrograde cardioplegia (if performed); and (b) not including valve replacement or repair or implantation of coronary arteries; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38550	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,460.40 **Benefit:** 75% = $1845.30
	Repair or replacement of ascending thoracic aorta: (a) including: (i) aortic valve replacement or repair; and (i) cardiopulmonary bypass; and (ii) retrograde cardioplegia (if performed); and (b) not including implantation of coronary arteries; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38553	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,097.65 **Benefit:** 75% = $2323.25
	Valve sparing aortic root surgery, with reimplantation of aortic valve and coronary arteries and replacement of the ascending aorta, including cardiopulmonary bypass, and including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38554	**Fee:** $4,459.20 **Benefit:** 75% = $3344.40

Fee 38555	Simple replacement or repair of aortic arch, performed in conjunction with a service to which item 38550, 38553, 38554, 38556, 38568 or 38571 applies, including: (a) deep hypothermic circulatory arrest; and (b) peripheral cannulation for cardiopulmonary bypass; and (c) antegrade or retrograde cerebral perfusion (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $2,736.70 **Benefit:** 75% = $2052.55
Fee 38556	Repair or replacement of ascending thoracic aorta, including: (a) aortic valve replacement or repair; and (b) implantation of coronary arteries; and (c) cardiopulmonary bypass; and (d) retrograde cardioplegia (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,400.35 **Benefit:** 75% = $2550.30
Fee 38557	Complex replacement or repair of aortic arch, performed in conjunction with a service to which item 38550, 38553, 38554, 38556, 38568 or 38571 applies, including: (a) debranching and reimplantation of head and neck vessels; and (b) deep hypothermic circulatory arrest; and (c) peripheral cannulation for cardiopulmonary bypass; and (d) antegrade or retrograde cerebral perfusion (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $4,736.60 **Benefit:** 75% = $3552.45
Fee 38558	Aortic repair involving augmentation of hypoplastic or interrupted aortic arch, if: (a) the patient is a neonate; and (b) the service includes: (i) the use of antegrade cerebral perfusion or deep hypothermic circulatory arrest and associated myocardial preservation; and (ii) retrograde cardioplegia;

	other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $5,351.00 **Benefit:** 75% = $4013.25
Fee 38568	Repair or replacement of descending thoracic aorta, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,040.35 **Benefit:** 75% = $1530.30
Fee 38571	Repair or replacement of descending thoracic aorta, with shunt or cardiopulmonary bypass, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,325.80 **Benefit:** 75% = $1744.35
Fee 38572	Operative management of acute rupture or dissection, if the service: (a) is performed in conjunction with a service to which item 38550, 38553, 38554, 38555, 38556, 38557, 38558, 38568, 38571, 38706 or 38709 applies; and (b) is not associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,176.35 **Benefit:** 75% = $1632.30
	CIRCULATORY SUPPORT PROCEDURES
Fee 38600	CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,677.85 **Benefit:** 75% = $1258.40
Fee 38603	Peripheral cannulation for cardiopulmonary bypass, excluding post-operative management, other than a service: (a) in which peripheral cannulation is used in preference to central cannulation for valve or coronary bypass procedures; or (b) associated with a service to which item 38555 or 38572 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,049.70 **Benefit:** 75% = $787.30
Fee 38609	Insertion of intra-aortic balloon pump, by arteriotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $524.80 **Benefit:** 75% = $393.60

	Removal of intra-aortic balloon pump, with closure of artery by direct suture, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 338816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38612	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $588.30 **Benefit:** 75% = $441.25
	Insertion of a left or right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; other than a service associated with a service to which: (d) item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies; or (e) another item in this Schedule applies if the service described in the item is for the use of a ventricular assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation (H) (Anaes.) (Assist.)
Fee 38615	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,677.85 **Benefit:** 75% = $1258.40
	Insertion of a left and right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; other than a service associated with a service to which: (d) item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies; or (e) another item in this Schedule applies if the service described in the item is for the use of a ventricular assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation
Fee 38618	(H) (Anaes.) (Assist.)

	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,091.40 **Benefit:** 75% = $1568.55
Fee 38621	Left or right ventricular assist device, removal of, as an independent procedure, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38627, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $834.95 **Benefit:** 75% = $626.25
Fee 38624	Left and right ventricular assist device, removal of, as an independent procedure, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38627, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $938.20 **Benefit:** 75% = $703.65
Fee 38627	Extra-corporeal membrane oxygenation, bypass or ventricular assist device cannulae, adjustment and re-positioning of, by open operation, in patients supported by these devices, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38627, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $733.35 **Benefit:** 75% = $550.05
	RE-OPERATION
Fee 38637	Patent diseased coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $607.35 **Benefit:** 75% = $455.55
	MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES
Fee 38653	Open heart surgery, other than a service: (a) to which another item in this Group applies; or (b) associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,200.40 **Benefit:** 75% = $1650.30
Fee 38764	Ventricular myectomy, for relief of right or left ventricular obstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $2,337.80 **Benefit:** 75% = $1753.35
	CARDIAC TUMOURS
Fee 38670	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,091.00 **Benefit:** 75% = $1568.25

Fee 38673	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,353.55 **Benefit:** 75% = $1765.20
Fee 38677	Cardiac tumour arising from ventricular myocardium, partial thickness excision of, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.75 **Benefit:** 75% = $1651.35
Amend Fee 38680	Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $2,611.65 **Benefit:** 75% = $1958.75
	CONGENITAL CARDIAC SURGERY
Fee 38474	Repair, augmentation or replacement of branch pulmonary arteries—left or right (or both), with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) **Fee:** $2,375.75 **Benefit:** 75% = $1781.85
Fee 38700	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,169.00 **Benefit:** 75% = $876.75
Fee 38703	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,114.50 **Benefit:** 75% = $1585.90
Fee 38706	Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,995.90 **Benefit:** 75% = $1496.95
Fee 38709	Anastomosis or repair of aorta, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,352.95 **Benefit:** 75% = $1764.75

	Main Pulmonary Artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38715	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,868.80 **Benefit:** 75% = $1401.60
	Banding, debanding or repair of main pulmonary artery, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38718	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,363.80 **Benefit:** 75% = $1772.85
	Vena Cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38721	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,638.30 **Benefit:** 75% = $1228.75
	Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38724	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,383.65 **Benefit:** 75% = $1787.75
	Anastomosis or repair of intrathoracic vessels, without cardiopulmonary bypass, performed as a primary procedure, other than a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38700, 38703, 38706, 38709, 38715, 38718, 38721, 38724, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38727	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,638.30 **Benefit:** 75% = $1228.75
	Anastomosis or repair of intrathoracic vessels, with cardiopulmonary bypass, performed as a primary procedure, other than a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38700, 38703, 38706, 38709, 38715, 38718, 38721, 38724, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38730	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,337.80 **Benefit:** 75% = $1753.35
	Systemic pulmonary or Cavo-pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38733	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,638.30 **Benefit:** 75% = $1228.75
	Systemic pulmonary or Cavo-pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38736	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,337.80 **Benefit:** 75% = $1753.35

	Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38739	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,143.65 **Benefit:** 75% = $1607.75
	Atrial septal defect, closure by open exposure and direct suture or patch, for congenital heart disease in a patient with documented evidence of right heart overload or paradoxical embolism, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38742	(See para TN.8.67, TN.8.210 of explanatory notes to this Category) **Fee:** $2,107.35 **Benefit:** 75% = $1580.55
	Intra-atrial baffle, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38745	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,337.80 **Benefit:** 75% = $1753.35
	Ventricular septectomy, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38748	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,337.80 **Benefit:** 75% = $1753.35
	Ventricular septal defect, closure by direct suture or patch, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38751	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,337.80 **Benefit:** 75% = $1753.35
	Intraventricular baffle or conduit, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38754	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,926.40 **Benefit:** 75% = $2194.80
	Extracardiac conduit, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38757	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,337.80 **Benefit:** 75% = $1753.35
	Extracardiac conduit, replacement of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)
Fee 38760	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,337.80 **Benefit:** 75% = $1753.35
Fee 38766	Ventricular augmentation, right or left, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)

T8. SURGICAL OPERATIONS	6. CARDIO-THORACIC
	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,337.80 **Benefit:** 75% = $1753.35
	MISCELLANEOUS PROCEDURES ON THE CHEST
Fee 38800	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies **Fee:** $42.15 **Benefit:** 75% = $31.65 85% = $35.85
Fee 38803	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample **Fee:** $84.25 **Benefit:** 75% = $63.20 85% = $71.65
Fee 38812	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.) **Fee:** $229.10 **Benefit:** 75% = $171.85 85% = $194.75

T8. SURGICAL OPERATIONS	7. NEUROSURGICAL
	Group T8. Surgical Operations
	Subgroup 7. Neurosurgical
Fee 39014	Medial branch block of one or more primary posterior rami, injection of an anaesthetic agent under image guidance (Anaes.) (See para TN.7.6, TN.8.4 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 39110	Left lumbar percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) (See para TN.8.245, TN.8.4 of explanatory notes to this Category) **Fee:** $293.55 **Benefit:** 75% = $220.20 85% = $249.55
Fee 39111	Right lumbar percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) (See para TN.8.245, TN.8.4 of explanatory notes to this Category) **Fee:** $293.55 **Benefit:** 75% = $220.20 85% = $249.55
Fee 39116	Left thoracic percutaneous zygapophyseal joint denervation by radio-frequency probe or cryoprobe using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) (See para TN.8.245, TN.8.4 of explanatory notes to this Category) **Fee:** $326.20 **Benefit:** 75% = $244.65 85% = $277.30
Fee 39117	Right thoracic percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control

	Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) (See para TN.8.245, TN.8.4 of explanatory notes to this Category) **Fee:** $326.20 **Benefit:** 75% = $244.65 85% = $277.30
Fee 39119	Right cervical percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) (See para TN.8.245, TN.8.4 of explanatory notes to this Category) **Fee:** $358.80 **Benefit:** 75% = $269.10 85% = $305.00
Fee 39129	Peripheral lead or leads, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain (H) (Anaes.) (Assist.) (See para TN.8.241 of explanatory notes to this Category) **Fee:** $664.50 **Benefit:** 75% = $498.40
	GENERAL
Fee 39000	LUMBAR PUNCTURE (Anaes.) **Fee:** $82.45 **Benefit:** 75% = $61.85 85% = $70.10
Fee 39007	Procedure to obtain access to intracranial space (including subdural space, ventricle or basal cistern), percutaneously or by burr-hole (Anaes.) **Fee:** $174.60 **Benefit:** 75% = $130.95 85% = $148.45
Fee 39013	Injection of one or more zygo-apophyseal or costo-transverse joints with one or more of contrast media, local anaesthetic or corticosteroid under image guidance (Anaes.) (See para TN.8.4, TN.8.240, TN.7.6, TN.7.5 of explanatory notes to this Category) **Fee:** $119.50 **Benefit:** 75% = $89.65 85% = $101.60
Fee 39015	Intracranial parenchymal pressure monitoring device, insertion of—including burr hole (excluding after care) (Anaes.) (See para TN.8.4, TN.8.166 of explanatory notes to this Category) **Fee:** $411.80 **Benefit:** 75% = $308.85
Fee 39018	Cerebrospinal reservoir, ventricular reservoir or external ventricular drain, insertion of, with or without stereotaxy (Anaes.) (Assist.) **Fee:** $905.35 **Benefit:** 75% = $679.05
	PAIN RELIEF
Fee 39100	Injection of primary branch of trigeminal nerve (ophthalmic, maxillary or mandibular branches) with alcohol, cortisone, phenol, or similar neurolytic substance, under image guidance (Anaes.) (See para TN.8.4, TN.7.6 of explanatory notes to this Category) **Fee:** $260.20 **Benefit:** 75% = $195.15 85% = $221.20
Fee 39109	Trigeminal gangliotomy by radiofrequency, balloon or glycerol, including stereotaxy (Anaes.) (Assist.)

	Fee: $1,552.60 **Benefit:** 75% = $1164.45 85% = $1459.40
Fee 39113	Cranial nerve, neurectomy or intracranial decompression of, using microsurgical techniques, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $2,604.55 **Benefit:** 75% = $1953.45
Fee 39118	Left cervical percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) (See para TN.8.4, TN.8.245, PN.0.34 of explanatory notes to this Category) **Fee:** $358.80 **Benefit:** 75% = $269.10 85% = $305.00
Fee 39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $691.90 **Benefit:** 75% = $518.95 85% = $598.70
Fee 39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) **Fee:** $1,770.75 **Benefit:** 75% = $1328.10
Fee 39125	Spinal catheter, insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $326.40 **Benefit:** 75% = $244.80
Fee 39126	All of the following: (a) infusion pump, subcutaneous implantation or replacement of; (b) connection of the pump to a spinal catheter; (c) filling of reservoir with a therapeutic agent or agents; with or without programming the pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $396.30 **Benefit:** 75% = $297.25
Fee 39127	Subcutaneous reservoir and spinal catheter, insertion of, for the management of chronic pain, including cancer pain (H) (Anaes.) (See para TN.8.4, TN.8.244 of explanatory notes to this Category) **Fee:** $518.80 **Benefit:** 75% = $389.10
Fee 39128	All of the following: (a) infusion pump, subcutaneous implantation of; (b) spinal catheter, insertion of;

	(c) connection of pump to catheter; (d) filling of reservoir with a therapeutic agent or agents; with or without programming the pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $722.75 **Benefit:** 75% = $542.10
Fee 39130	Epidural lead or leads, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.) (See para TN.8.4, TN.8.244 of explanatory notes to this Category) **Fee:** $738.30 **Benefit:** 75% = $553.75
Fee 39131	Epidural or peripheral nerve electrodes (management, adjustment, or reprogramming of neurostimulator), with a medical practitioner attending, for the management of chronic neuropathic pain or pain from refractory angina pectoris—each day (See para TN.8.244, TN.8.253 of explanatory notes to this Category) **Fee:** $140.00 **Benefit:** 75% = $105.00 85% = $119.00
Fee 39133	Either: (a) subcutaneously implanted infusion pump, removal of; or (b) spinal catheter, removal or repositioning of; for the management of chronic pain, including cancer pain (H) (Anaes.) (See para TN.8.4, TN.8.244 of explanatory notes to this Category) **Fee:** $174.60 **Benefit:** 75% = $130.95
Fee 39134	Neurostimulator or receiver, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $373.00 **Benefit:** 75% = $279.75
Fee 39135	Neurostimulator or receiver that was inserted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical removal of, performed in the operating theatre of a hospital (H) (Anaes.) (Assist.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $174.60 **Benefit:** 75% = $130.95
Fee 39136	Epidural or peripheral nerve lead that was implanted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical removal of, performed in the operating theatre of a hospital (H) (Anaes.) (Assist.) (See para TN.8.4, TN.8.244 of explanatory notes to this Category) **Fee:** $174.60 **Benefit:** 75% = $130.95
Fee 39137	Epidural or peripheral nerve lead that was implanted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical repositioning of, to correct displacement or

	unsatisfactory positioning, including intraoperative test stimulation, other than a service to which item 39130, 39138 or 39139 applies (H) (Anaes.) (Assist.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $663.05 **Benefit:** 75% = $497.30
Fee 39138	Peripheral nerve lead or leads, surgical placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain where the leads are intended to remain in situ long term (H) (Anaes.) (Assist.) (See para TN.8.241 of explanatory notes to this Category) **Fee:** $738.30 **Benefit:** 75% = $553.75
Fee 39139	Epidural lead, surgical placement of one or more of by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $991.30 **Benefit:** 75% = $743.50
Fee 39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) **Fee:** $320.75 **Benefit:** 75% = $240.60 85% = $272.65
Fee 39141	Epidural or peripheral nerve electrodes (management, adjustment, or reprogramming of neurostimulator), with a medical practitioner attending remotely by video conference, for the management of chronic neuropathic pain or pain from refractory angina pectoris—each day (See para TN.8.244, TN.8.253 of explanatory notes to this Category) **Fee:** $140.00 **Benefit:** 75% = $105.00 85% = $119.00
	PERIPHERAL NERVES
Fee 39300	Nerve, digital or cutaneous, primary repair of, using microsurgical techniques, other than a service associated with a service to which item 39330 applies—applicable once per nerve (H) (Anaes.) (Assist.) **Fee:** $387.05 **Benefit:** 75% = $290.30
Fee 39303	Nerve, digital or cutaneous, delayed repair of, using microsurgical techniques, including either or both of the following (if performed): (a) neurolysis; (b) transposition of nerve to facilitate repair; other than a service associated with a service to which item 30023 applies—applicable once per nerve (H) (Anaes.) (Assist.) **Fee:** $510.50 **Benefit:** 75% = $382.90
Fee 39306	Nerve trunk, primary repair of, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.) **Fee:** $741.25 **Benefit:** 75% = $555.95
Fee 39307	Reconstruction of nerve trunk using biological or synthetic nerve conduit, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (Anaes.) (Assist.) **Fee:** $902.60 **Benefit:** 75% = $676.95 85% = $809.40

Fee 39309	Nerve trunk, delayed repair of, using microsurgical techniques, including either or both of the following (if performed): (a) neurolysis; (b) transposition of nerve or nerve transfer to facilitate repair; other than a service associated with a service to which item 30023 or 39321 applies (H) (Anaes.) (Assist.) **Fee:** $782.45 **Benefit:** 75% = $586.85
Fee 39312	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques, other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.) **Fee:** $436.50 **Benefit:** 75% = $327.40
Fee 39315	Nerve trunk, nerve graft to, by cable graft, using microsurgical techniques, including any of the following (if performed): (a) harvesting of nerve graft; (b) proximal and distal anastomosis of nerve graft; (c) transposition of nerve to facilitate grafting; (d) neurolysis; other than a service associated with a service to which item 30023 or 39330 applies (H) (Anaes.) (Assist.) **Fee:** $1,128.30 **Benefit:** 75% = $846.25
Fee 39318	Nerve, digital or cutaneous, nerve graft to, using microsurgical techniques, including either or both of the following (if performed): (a) harvesting of nerve graft from separate donor site; (b) proximal and distal anastomosis of nerve graft; other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.) **Fee:** $700.15 **Benefit:** 75% = $525.15
Fee 39319	Reconstruction of digital or cutaneous nerve using biological or synthetic nerve conduit, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (Anaes.) (Assist.) **Fee:** $510.50 **Benefit:** 75% = $382.90 85% = $433.95
Fee 39321	Transposition of nerve, excluding the ulnar nerve at the elbow, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.) (See para TN.8.189, TN.8.254 of explanatory notes to this Category) **Fee:** $518.80 **Benefit:** 75% = $389.10
Fee 39323	Percutaneous denervation (excluding medial branch nerve) by cryotherapy or radiofrequency probe, other than a service to which another item applies, applicable not more than 6 times for a given nerve in a 12 month period (Anaes.)

	(See para TN.8.245 of explanatory notes to this Category) **Fee:** $303.15 **Benefit:** 75% = $227.40 85% = $257.70
Fee 39324	Neurectomy or removal of tumour or neuroma from superficial peripheral nerve (Anaes.) (Assist.) (See para TN.8.4, TN.8.254 of explanatory notes to this Category) **Fee:** $303.15 **Benefit:** 75% = $227.40 85% = $257.70
Fee 39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral or cranial nerve, by open operation, not being a service to which item 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist.) (See para TN.8.4, TN.8.254 of explanatory notes to this Category) **Fee:** $518.90 **Benefit:** 75% = $389.20
Fee 39328	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve, by open operation, for upper limb surgery (H) (Anaes.) (Assist.) **Fee:** $518.90 **Benefit:** 75% = $389.20
Amend Fee 39329	Extensive neurolysis of radial, median or ulnar nerve trunk nerve in the forearm or arm, other than a service associated with a service to which item 30023, 39303, 39309, 39312, 39315, 39318, 39324 or 39327 applies (Anaes.) (Assist.) (See para TN.8.186 of explanatory notes to this Category) **Fee:** $387.05 **Benefit:** 75% = $290.30 85% = $329.00
Fee 39330	Neurolysis by open operation without transposition, other than a service associated with a service to which item 30023, 39321, 39328, 39329, 39332, 39336, 39339, 39342, 39345, 49774 or 49775 applies (H) (Anaes.) (Assist.) (See para TN.8.200, TN.8.196, TN.8.254 of explanatory notes to this Category) **Fee:** $303.15 **Benefit:** 75% = $227.40
Fee 39331	Carpal tunnel release, including division of transverse carpal ligament or release of median nerve, by any method, including either or both of the following (if performed): (a) synovectomy; (b) neurolysis Other than a service associated with a service to which item 30023 or 46339 applies (Anaes.) (Assist.) **Fee:** $303.15 **Benefit:** 75% = $227.40 85% = $257.70
Fee 39332	Revision of carpal tunnel release, including division of transverse carpal ligament or release of median nerve, by any method, including either or both of the following (if performed): (a) synovectomy; (b) neurolysis; other than a service associated with a service to which item 30023 or 46339 applies. (Anaes.) (Assist.) **Fee:** $454.75 **Benefit:** 75% = $341.10 85% = $386.55

Fee 39336	Ulnar nerve decompression at elbow or wrist (cubital tunnel or Guyon's canal) without transposition, by any method, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.) (Assist.) **Fee:** $303.15 **Benefit:** 75% = $227.40 85% = $257.70
Fee 39339	Revision of ulnar nerve decompression at elbow (cubital tunnel) without transposition, by any method, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.) (Assist.) **Fee:** $454.75 **Benefit:** 75% = $341.10 85% = $386.55
Fee 39342	Ulnar nerve decompression at elbow (cubital tunnel), including any of the following (if performed): (a) associated transposition; (b) subcutaneous or submuscular transposition of the nerve; (c) medial epicondylectomy; (d) ostetomy and reconstruction of the flexor origin; (e) neurolysis; other than a service associated with a service to which item 30023 applies (Anaes.) (Assist.) **Fee:** $596.55 **Benefit:** 75% = $447.45 85% = $507.10
Fee 39345	Localised decompression of radial, median or ulnar nerve, or branches of, in the forearm for compressive neuropathy, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.) (Assist.) (See para TN.8.186 of explanatory notes to this Category) **Fee:** $303.15 **Benefit:** 75% = $227.40 85% = $257.70
	CRANIAL NERVES
Fee 39503	Facio-hypoglossal nerve or facio-accessory nerve, anastomosis of (Anaes.) (Assist.) (See para TN.8.166 of explanatory notes to this Category) **Fee:** $1,045.95 **Benefit:** 75% = $784.50
	CRANIO-CEREBRAL INJURIES
Fee 39604	Any of the following procedures for intracranial haemorrhage or swelling: (a) craniotomy, craniectomy or burr-holes for removal of intracranial haemorrhage, including stereotaxy; (b) craniotomy or craniectomy for brain swelling, stroke, or raised intracranial pressure, including for subtemporal decompression, including stereotaxy; or (c) post-operative re-opening, including for swelling or post-operative cerebrospinal fluid leak. (Anaes.) (Assist.) **Fee:** $1,964.35 **Benefit:** 75% = $1473.30
Fee 39610	Fractured skull, without brain laceration or dural penetration, repair of (Anaes.) (Assist.) **Fee:** $1,045.95 **Benefit:** 75% = $784.50
Fee 39612	Fractured skull, with brain laceration or dural penetration but without cerebrospinal fluid, rhinorrhoea or otorrhoea, repair of (Anaes.) (Assist.)

	Fee: $1,227.20 **Benefit:** 75% = $920.40
Fee 39615	Fractured skull, after trauma, with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (Anaes.) (Assist.) **Fee:** $2,094.10 **Benefit:** 75% = $1570.60
	SKULL BASE SURGERY
Fee 39638	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—conjoint surgery, principal surgeon (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $4,662.50 **Benefit:** 75% = $3496.90
Fee 39639	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—conjoint surgery, co-surgeon (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $3,725.85 **Benefit:** 75% = $2794.40
Fee 39641	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty - one surgeon (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $4,917.80 **Benefit:** 75% = $3688.35
Fee 39651	Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty - one surgeon (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $6,067.35 **Benefit:** 75% = $4550.55
Fee 39654	Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—conjoint surgery, principal surgeon (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $4,662.50 **Benefit:** 75% = $3496.90
Fee 39656	Petro clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—conjoint surgery, co surgeon (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $3,725.85 **Benefit:** 75% = $2794.40
	INTRA-CRANIAL NEOPLASMS
Fee 39700	Skull tumour, benign or malignant, excision of, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $1,984.90 **Benefit:** 75% = $1488.70
Fee 39703	Intracranial tumour, cyst or other brain tissue, either or both of: (a) burr hole and biopsy of; (b) drainage of; including stereotaxy (Anaes.) (Assist.) **Fee:** $1,593.85 **Benefit:** 75% = $1195.40
Fee 39710	Intracranial tumour, one or more, biopsy, drainage, decompression or removal of, through a single craniotomy, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $2,654.20 **Benefit:** 75% = $1990.65

Fee 39712	Transcranial tumour removal or biopsy of one or more of any of the following: (a) meningioma; (b) pinealoma; (c) cranio pharyngioma; (d) pituitary tumour; (e) intraventricular lesion; (f) brain stem lesion; (g) any other intracranial tumour; by any means (with or without endoscopy), through a single craniotomy, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $4,054.20 **Benefit:** 75% = $3040.65
Fee 39715	Pituitary tumour, removal of, by transphenoidal approach, including stereotaxy and dermis, dermofat or fascia grafting, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) **Fee:** $2,958.85 **Benefit:** 75% = $2219.15
Fee 39718	Arachnoidal cyst, craniotomy for, including stereotaxy and neuroendoscopy (Anaes.) (Assist.) **Fee:** $1,787.30 **Benefit:** 75% = $1340.50
Fee 39720	Awake craniotomy for functional neurosurgery (Anaes.) (Assist.) **Fee:** $3,792.65 **Benefit:** 75% = $2844.50
	CEREBROVASCULAR DISEASE
Fee 39801	Aneurysm, clipping, proximal ligation, or reinforcement of sac, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $6,067.35 **Benefit:** 75% = $4550.55
Fee 39803	Intracranial arteriovenous malformation or fistula, treatment through a craniotomy, including stereotaxy, cranioplasty and all angiography (Anaes.) (Assist.) **Fee:** $6,067.35 **Benefit:** 75% = $4550.55
Fee 39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.) **Fee:** $2,001.25 **Benefit:** 75% = $1500.95 85% = $1908.05
Fee 39818	Intracranial vascular bypass using indirect techniques, including stereotaxy (Anaes.) (Assist.) **Fee:** $2,656.15 **Benefit:** 75% = $1992.15
Fee 39821	Intracranial vascular bypass using direct anastomosis techniques, including stereotaxy (Anaes.) (Assist.) **Fee:** $3,784.45 **Benefit:** 75% = $2838.35
Fee 40004	Ventricular, lumbar or cisternal shunt diversion, insertion or revision of, including stereotaxy (Anaes.) (Assist.) **Fee:** $1,812.00 **Benefit:** 75% = $1359.00
	INFECTION
Fee 39900	Intracranial infection, treated by burr hole, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)

	Fee: $1,593.85 **Benefit:** 75% = $1195.40
Fee 39903	Intracranial infection, treated by craniotomy, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) **Fee:** $2,392.70 **Benefit:** 75% = $1794.55
Fee 39906	Osteomyelitis of skull or removal of infected bone flap, craniectomy for, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) (See para TN.8.166 of explanatory notes to this Category) **Fee:** $873.00 **Benefit:** 75% = $654.75
	CEREBROSPINAL FLUID CIRCULATION DISORDERS
Fee 40012	Endoscopic ventriculostomy for treatment of cerebrospinal fluid circulation disorders, including stereotaxy (Anaes.) (Assist.) **Fee:** $1,873.80 **Benefit:** 75% = $1405.35
Fee 40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes.) **Fee:** $174.60 **Benefit:** 75% = $130.95 85% = $148.45
	CONGENITAL DISORDERS
Fee 40104	Spinal myelomeningocele or spinal meningocele, excision and closure of, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) (See para TN.8.166 of explanatory notes to this Category) **Fee:** $1,111.90 **Benefit:** 75% = $833.95
Fee 40106	Chiari malformation, decompression or reconstruction of, including laminectomy, dermofat graft and stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) **Fee:** $2,639.60 **Benefit:** 75% = $1979.70
Fee 40109	Encephalocoele or cranial meningocele, excision and closure of, including stereotaxy and dermofat graft (Anaes.) (Assist.) **Fee:** $2,048.75 **Benefit:** 75% = $1536.60
Fee 40112	Tethered cord, release of, including lipomeningocele or diastematomyelia, multiple levels, including laminectomy and rhizolysis, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) **Fee:** $2,617.10 **Benefit:** 75% = $1962.85
Fee 40119	Craniostenosis, operation for, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) **Fee:** $1,045.95 **Benefit:** 75% = $784.50
	SKULL RECONSTRUCTION
Fee 40600	Cranioplasty, reconstructive, other than a service associated with a service to which item 39113, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39710, 39712, 39715, 39801, 39803, 40703 or 41887 applies (H) (Anaes.) (Assist.) **Fee:** $1,045.95 **Benefit:** 75% = $784.50
	EPILEPSY
Fee 40700	Corpus callosotomy, for epilepsy, including stereotaxy (Anaes.) (Assist.)

	Fee: $2,565.60 **Benefit:** 75% = $1924.20
Fee 40701	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, subcutaneous placement of electrical pulse generator, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.) **Fee:** $373.00 **Benefit:** 75% = $279.75
Fee 40702	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of electrical pulse generator inserted for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.) **Fee:** $174.60 **Benefit:** 75% = $130.95
Fee 40703	Corticectomy, topectomy or partial lobectomy, for epilepsy, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $2,654.20 **Benefit:** 75% = $1990.65
Fee 40704	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical placement of lead, including connection of lead to left vagus nerve and intra-operative test stimulation, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.) **Fee:** $738.30 **Benefit:** 75% = $553.75
Fee 40705	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of lead attached to left vagus nerve for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.) **Fee:** $663.05 **Benefit:** 75% = $497.30
Fee 40706	Hemispherectomy or functional hemispherectomy, for intractable epilepsy, including stereotaxy (Anaes.) (Assist.) **Fee:** $3,792.70 **Benefit:** 75% = $2844.55
Fee 40707	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, electrical analysis and programming of vagus nerve stimulation therapy device using external wand, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery **Fee:** $207.75 **Benefit:** 75% = $155.85 85% = $176.60
Fee 40708	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical replacement of battery in electrical pulse generator inserted for:

	(a) management of refractory generalised epilepsy; or (b) treating refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.) **Fee:** $373.00 **Benefit:** 75% = $279.75
Fee 40709	Intracranial electrode placement by burr hole, including stereotaxy (Anaes.) (Assist.) **Fee:** $1,593.85 **Benefit:** 75% = $1195.40
Fee 40712	Intracranial electrode placement by craniotomy, single or multiple, including stereotactic EEG, including stereotaxy (Anaes.) (Assist.) **Fee:** $3,792.70 **Benefit:** 75% = $2844.55
	STEREOTACTIC PROCEDURES
Fee 40801	Functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation, and lesion production, by any method, in the basal ganglia, brain stem or deep white matter tracts, other than a service associated with deep brain stimulation for Parkinson's disease, essential tremor or dystonia (Anaes.) (Assist.) **Fee:** $1,912.05 **Benefit:** 75% = $1434.05
Fee 40803	Intracranial stereotactic procedure by any method, other than: (a) a service to which item 40801 applies; or (b) a service associated with a service to which item 39018, 39109, 39113, 39604, 39615, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39703, 39710, 39712, 39715, 39718, 39720, 39801, 39803, 39818, 39821, 39900, 39903, 40004, 40012, 40106, 40109, 40700, 40703, 40706, 40709 or 40712 applies (Anaes.) (Assist.) (See para TN.8.166 of explanatory notes to this Category) **Fee:** $1,309.55 **Benefit:** 75% = $982.20 85% = $1216.35
Fee 40850	DEEP BRAIN STIMULATION (unilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability (Anaes.) (Assist.) **Fee:** $2,480.10 **Benefit:** 75% = $1860.10
Fee 40851	DEEP BRAIN STIMULATION (bilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.)

	Fee: $4,340.45 **Benefit:** 75% = $3255.35
Fee 40852	DEEP BRAIN STIMULATION (unilateral) subcutaneous placement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.) **Fee:** $373.00 **Benefit:** 75% = $279.75
Fee 40854	DEEP BRAIN STIMULATION (unilateral) revision or removal of brain electrode for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $576.50 **Benefit:** 75% = $432.40
Fee 40856	DEEP BRAIN STIMULATION (unilateral) removal or replacement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $279.75 **Benefit:** 75% = $209.85
Fee 40858	DEEP BRAIN STIMULATION (unilateral) placement, removal or replacement of extension lead for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $576.50 **Benefit:** 75% = $432.40
Fee 40860	DEEP BRAIN STIMULATION (unilateral) target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)

T8. SURGICAL OPERATIONS	7. NEUROSURGICAL
	Fee: $2,215.30 **Benefit:** 75% = $1661.50
Fee 40862	DEEP BRAIN STIMULATION (unilateral) electronic analysis and programming of neurostimulator pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $207.75 **Benefit:** 75% = $155.85 85% = $176.60
Fee 40863	Deep brain stimulation (unilateral), remote electronic analysis and programming of neurostimulator pulse generator for the treatment of: (a) Parkinson’s disease, if the patient’s response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient’s symptoms cause severe disability Applicable not more than 8 times in any 12 month period **Fee:** $207.75 **Benefit:** 75% = $155.85 85% = $176.60
	MISCELLANEOUS
Fee 40905	Craniotomy, performed by a neurosurgeon in conjunction with the correction of craniofacial abnormalities (Anaes.) (Assist.) **Fee:** $659.00 **Benefit:** 75% = $494.25

T8. SURGICAL OPERATIONS	8. EAR, NOSE AND THROAT
	Group T8. Surgical Operations
	Subgroup 8. Ear, Nose And Throat
Fee 41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) (See para TN.8.72 of explanatory notes to this Category) **Fee:** $90.30 **Benefit:** 75% = $67.75 85% = $76.80
Fee 41501	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 (See para TN.8.76 of explanatory notes to this Category) **Fee:** $203.25 **Benefit:** 75% = $152.45 85% = $172.80

Fee 41503	Ear, foreign body in (other than ventilating tube), removal of, involving incision of external auditory canal, other than a service associated with a service to which another item in this Subgroup applies (Anaes.) **Fee:** $261.55 **Benefit:** 75% = $196.20 85% = $222.35
Fee 41506	AURAL POLYP, removal of (Anaes.) **Fee:** $157.75 **Benefit:** 75% = $118.35 85% = $134.10
Fee 41509	External auditory meatus, surgical removal of keratosis obturans from, performed under general anaesthesia, other than: (a) a service to which another item in this Subgroup applies; or (b) a service associated with a service to which item 41647 applies (H) (Anaes.) **Fee:** $178.45 **Benefit:** 75% = $133.85
Fee 41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.) **Fee:** $641.70 **Benefit:** 75% = $481.30
Fee 41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assist.) (See para TN.8.73 of explanatory notes to this Category) **Fee:** $421.15 **Benefit:** 75% = $315.90
Fee 41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.) **Fee:** $1,017.15 **Benefit:** 75% = $762.90
Fee 41521	Correction of auditory canal stenosis, including meatoplasty, with or without grafting, other than a service associated with a service to which an item in Subgroup 18 applies (H) (Anaes.) (Assist.) **Fee:** $1,083.00 **Benefit:** 75% = $812.25
Fee 41524	Reconstruction of external auditory canal (H) (Anaes.) (Assist.) (See para TN.8.74 of explanatory notes to this Category) **Fee:** $312.85 **Benefit:** 75% = $234.65
Fee 41539	Ossicular chain reconstruction, other than a service associated with a service to which item 41611 applies (H) (Anaes.) (Assist.) **Fee:** $1,193.70 **Benefit:** 75% = $895.30
Fee 41542	Ossicular chain reconstruction and myringoplasty, other than a service associated with a service to which item 41611 applies (H) (Anaes.) (Assist.) **Fee:** $1,308.00 **Benefit:** 75% = $981.00
Fee 41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) **Fee:** $757.55 **Benefit:** 75% = $568.20
Fee 41569	Decompression of facial nerve in its mastoid portion, other than a service associated with a service to which item 41617 applies (H) (Anaes.) (Assist.) **Fee:** $1,308.00 **Benefit:** 75% = $981.00

Fee 41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) **Fee:** $1,131.60 **Benefit:** 75% = $848.70
Fee 41575	CEREBELLO PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.) **Fee:** $2,667.60 **Benefit:** 75% = $2000.70
Fee 41576	CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.) (Assist.) **Fee:** $4,001.55 **Benefit:** 75% = $3001.20
Fee 41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,667.60 **Benefit:** 75% = $2000.70
Fee 41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) **Fee:** $2,000.70 **Benefit:** 75% = $1500.55
Fee 41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) **Fee:** $3,068.30 **Benefit:** 75% = $2301.25
Fee 41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) **Fee:** $2,105.70 **Benefit:** 75% = $1579.30
Fee 41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) **Fee:** $2,867.95 **Benefit:** 75% = $2151.00
Fee 41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.) **Fee:** $1,308.00 **Benefit:** 75% = $981.00
Fee 41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) **Fee:** $1,704.70 **Benefit:** 75% = $1278.55
Fee 41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) **Fee:** $1,905.15 **Benefit:** 75% = $1428.90
Fee 41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) **Fee:** $1,905.15 **Benefit:** 75% = $1428.90
Fee 41603	Osseo-integration procedure-implantation of bone conduction hearing system device, in a patient: (a) With a permanent or long-term hearing loss; and

	(b) Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and (c) With bone conduction thresholds that accord with recognised criteria for the implantable bone conduction hearing device being inserted. other than a service associated with a service to which item 41554, 45794 or 45797 applies (Anaes.) **Fee:** $654.05 **Benefit:** 75% = $490.55 85% = $560.85
Fee 41608	STAPEDECTOMY (Anaes.) (Assist.) **Fee:** $1,193.70 **Benefit:** 75% = $895.30
Fee 41611	Stapes mobilisation, other than a service associated with a service to which item 41539, 41542, or an item in Subgroup 18, applies (H) (Anaes.) (Assist.) **Fee:** $768.10 **Benefit:** 75% = $576.10
Fee 41614	Round window surgery including repair of cochleotomy, other than a service associated with a service to which item 41617 applies (Anaes.) (Assist.) **Fee:** $1,193.70 **Benefit:** 75% = $895.30 85% = $1100.50
Fee 41615	OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.) (Assist.) **Fee:** $1,193.70 **Benefit:** 75% = $895.30 85% = $1100.50
Fee 41617	Cochlear implant, insertion of, including mastoidectomy, cochleotomy and exposure of facial nerve where required, other than a service associated with a service to which item 41569 or 41614 applies (H) (Anaes.) (Assist.) **Fee:** $2,075.70 **Benefit:** 75% = $1556.80
Fee 41618	Middle ear implant, partially implantable, insertion of, via mastoidectomy, for patients with: (a) stable sensorineural hearing loss; and (b) outer ear pathology that prevents the use of a conventional hearing aid; and (c) a PTA4 of less than 80 dBHL; and (d) bilateral, symmetrical hearing loss with PTA thresholds in both ears within 20 dBHL (0.5-4kHz) of each other; and (e) speech perception discrimination of at least 65% correct for word lists with appropriately amplified sound; and (f) a normal middle ear; and (g) normal 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.) **Fee:** $2,055.70 **Benefit:** 75% = $1541.80

Fee 41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) **Fee:** $903.10 **Benefit:** 75% = $677.35
Fee 41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,308.00 **Benefit:** 75% = $981.00
Fee 41626	Incision of tympanic membrane, or installation of therapeutic agent, to the middle ear through an intact drum: (a) not including local anaesthetic; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 41632 applies (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $157.75 **Benefit:** 75% = $118.35 85% = $134.10
Fee 41632	Middle ear, insertion of tube for drainage of (including myringotomy), other than a service associated with a service to which item 41626 applies (Anaes.) **Fee:** $261.55 **Benefit:** 75% = $196.20 85% = $222.35
Fee 41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.) **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
Fee 41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) **Fee:** $156.50 **Benefit:** 75% = $117.40 85% = $133.05
Fee 41647	Micro inspection of tympanic membrane and auditory canal, requiring use of operating microscope or endoscope, including any removal of wax, with or without general anaesthesia, other than a service associated with a service to which item 41509 applies. Not applicable for the removal of uncomplicated wax in the absence of other disorders of the ear (Anaes.) (See para TN.8.255 of explanatory notes to this Category) **Fee:** $120.35 **Benefit:** 75% = $90.30 85% = $102.30
Fee 41650	TYMPANIC MEMBRANE, microinspection of 1 or both ears under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $120.35 **Benefit:** 75% = $90.30 85% = $102.30
Fee 41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $134.50 **Benefit:** 75% = $100.90 85% = $114.35
Fee 41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.) **Fee:** $84.95 **Benefit:** 75% = $63.75 85% = $72.25
Fee 41662	Nasal polyp or polypi (simple), removal of, other than a service associated with a service to which item 41702, 41703 or 41705 applies on the same side (See para TN.8.75 of explanatory notes to this Category) **Fee:** $90.30 **Benefit:** 75% = $67.75 85% = $76.80

Fee 41668	Nasal polyp or polypi, removal of (Anaes.) (See para TN.8.75 of explanatory notes to this Category) **Fee:** $240.85 **Benefit:** 75% = $180.65 85% = $204.75
Fee 41674	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum or turbinates—one or more of these procedures (including any consultation on the same occasion) other than a service associated with another operation on the nose (Anaes.) **Fee:** $110.05 **Benefit:** 75% = $82.55 85% = $93.55
Fee 41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $98.60 **Benefit:** 75% = $73.95 85% = $83.85
Fee 41683	DIVISION OF NASAL ADHESIONS, with or without stenting not being a service associated with any other operation on the nose and not performed during the postoperative period of a nasal operation (Anaes.) **Fee:** $128.40 **Benefit:** 75% = $96.30 85% = $109.15
Fee 41686	DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $78.80 **Benefit:** 75% = $59.10 85% = $67.00
Fee 41698	Maxillary antrum, proof puncture and lavage of, other than a service associated with a service to which item 41702, 41703, 41705, 41710, 41734 or 41737 applies on the same side (Anaes.) **Fee:** $35.65 **Benefit:** 75% = $26.75 85% = $30.35
Fee 41701	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $100.65 **Benefit:** 75% = $75.50
Fee 41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $39.80 **Benefit:** 75% = $29.85 85% = $33.85
Fee 41707	Maxillary or sphenopalatine artery, ligation of (H) (Anaes.) (Assist.) (See para TN.8.256 of explanatory notes to this Category) **Fee:** $491.25 **Benefit:** 75% = $368.45
Fee 41713	Vidian neurectomy or exposure of vidian canal (H) (Anaes.) (Assist.) **Fee:** $664.30 **Benefit:** 75% = $498.25
Fee 41719	Antrum, drainage of, through tooth socket, other than a service associated with a service to which item 41722 applies (Anaes.) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
Fee 41722	Oroantral fistula, plastic closure of, other than a service associated with a service to which item 41719 or 45009 applies (Anaes.) (Assist.) **Fee:** $643.55 **Benefit:** 75% = $482.70 85% = $550.35

Fee 41725	Ligation of ethmoidal artery or arteries, anterior, posterior or both, by any approach (unilateral) (H) (Anaes.) (Assist.) (See para TN.8.256 of explanatory notes to this Category) **Fee:** $491.25 **Benefit:** 75% = $368.45
Fee 41728	Removal of sinonasal or nasopharyngeal tumour, excluding inflammatory nasal polyps, by any approach (H) (Anaes.) (Assist.) **Fee:** $982.75 **Benefit:** 75% = $737.10
Fee 41740	Frontal sinus, catheterisation of, other than a service associated with a service to which item 41749 applies (Anaes.) **Fee:** $64.45 **Benefit:** 75% = $48.35
Fee 41743	Frontal sinus, trephine of, other than a service associated with a service to which item 41749 applies (H) (Anaes.) (Assist.) **Fee:** $369.60 **Benefit:** 75% = $277.20
Fee 41746	Paranasal sinus, radical obliteration of, including any graft harvest (Anaes.) (Assist.) **Fee:** $851.15 **Benefit:** 75% = $638.40 85% = $757.95
Fee 41749	Paranasal sinus, external operation on, unilateral, other than a service associated with a service to which item 41740 or 41743 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $664.30 **Benefit:** 75% = $498.25
Fee 41755	EUSTACHIAN TUBE, catheterisation of (Anaes.) **Fee:** $50.90 **Benefit:** 75% = $38.20 85% = $43.30
Fee 41764	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx and larynx, one or more of these procedures, unilateral or bilateral examination, other than a service associated with a service to which item 41693, 41702, 41703, 41705, 41734 or 41737 applies (Anaes.) (See para TN.8.257 of explanatory notes to this Category) **Fee:** $134.50 **Benefit:** 75% = $100.90 85% = $114.35
Fee 41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.) **Fee:** $768.10 **Benefit:** 75% = $576.10
Fee 41776	Cricopharyngeal myotomy by any approach, including open inversion of pharyngeal pouch or endoscopic repair of pharyngeal pouch (H) (Anaes.) (Assist.) **Fee:** $642.60 **Benefit:** 75% = $481.95
Fee 41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) **Fee:** $768.10 **Benefit:** 75% = $576.10
Fee 41785	Partial pharyngectomy, by any approach, with or without partial glossectomy (H) (Anaes.) (Assist.) **Fee:** $1,249.00 **Benefit:** 75% = $936.75
Fee 41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) **Fee:** $807.20 **Benefit:** 75% = $605.40

Fee 41789	Tonsils or tonsils and adenoids, removal of, in a patient aged less than 12 years (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.) **Fee:** $323.85 **Benefit:** 75% = $242.90
Fee 41793	Tonsils or tonsils and adenoids, removal of, in a patient 12 years of age or over (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.) **Fee:** $406.90 **Benefit:** 75% = $305.20
Fee 41797	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) **Fee:** $157.75 **Benefit:** 75% = $118.35
Fee 41801	Adenoids, removal of (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.) **Fee:** $178.45 **Benefit:** 75% = $133.85
Fee 41804	Removal of lingual tonsil (H) (Anaes.) **Fee:** $98.60 **Benefit:** 75% = $73.95
Fee 41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.) **Fee:** $76.70 **Benefit:** 75% = $57.55 85% = $65.20
Fee 41810	UVULOTOMY or UVULECTOMY (Anaes.) **Fee:** $39.00 **Benefit:** 75% = $29.25 85% = $33.15
Fee 41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) **Fee:** $390.30 **Benefit:** 75% = $292.75
Fee 41822	Oesophagoscopy, with rigid oesophagoscope, with or without biopsy, other than a service associated with a service to which item 30473 or 30478 applies (H) (Anaes.) **Fee:** $210.50 **Benefit:** 75% = $157.90
Fee 41825	Removal of a foreign body from the pharynx, larynx or oesophagus, by any means, other than a service associated with a service to which item 30478 applies (H) (Anaes.) (Assist.) **Fee:** $390.30 **Benefit:** 75% = $292.75
Fee 41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.) **Fee:** $57.20 **Benefit:** 75% = $42.90 85% = $48.65
Fee 41831	Oesophagus, endoscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.) **Fee:** $391.00 **Benefit:** 75% = $293.25 85% = $332.35
Fee 41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.) **Fee:** $250.25 **Benefit:** 75% = $187.70 85% = $212.75

Fee 41834	Total laryngectomy, including cricopharyngeal myotomy and tracheo oesophageal puncture (H) (Anaes.) (Assist.) **Fee:** $1,732.80 **Benefit:** 75% = $1299.60
Fee 41837	Complete vertical hemi laryngectomy, involving removal of true and false vocal cords, including tracheostomy. Applicable only once per provider per patient per lifetime (H) (Anaes.) (Assist.) (See para TN.8.258 of explanatory notes to this Category) **Fee:** $1,353.80 **Benefit:** 75% = $1015.35
Fee 41840	Total supraglottic laryngectomy, involving removal of ventricular folds, epiglottis and aryepiglottic folds including tracheostomy. Applicable only once per provider per patient per lifetime (H) (Anaes.) (Assist.) (See para TN.8.258 of explanatory notes to this Category) **Fee:** $1,664.50 **Benefit:** 75% = $1248.40
Fee 41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) **Fee:** $1,463.70 **Benefit:** 75% = $1097.80
Fee 41855	Microlaryngoscopy, by any approach, with or without biopsy (H) (Anaes.) (Assist.) **Fee:** $315.60 **Benefit:** 75% = $236.70
Fee 41861	Microlaryngoscopy with complete removal of benign or malignant lesions of the larynx, including papillomata, by any approach or technique, unilateral, other than a service associated with a service to which item 41870 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $661.80 **Benefit:** 75% = $496.35
Fee 41867	Microlaryngoscopy, with partial or complete arytenoidectomy or arytenoid repositioning (H) (Anaes.) (Assist.) **Fee:** $671.80 **Benefit:** 75% = $503.85
Fee 41870	Laryngeal augmentation or modification by injection techniques, other than a service associated with a service to which item 41861 or 41879 applies (Anaes.) (Assist.) **Fee:** $498.15 **Benefit:** 75% = $373.65 85% = $423.45
Fee 41873	Larynx, fractured, operation for (H) (Anaes.) (Assist.) **Fee:** $643.55 **Benefit:** 75% = $482.70
Fee 41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.) **Fee:** $643.55 **Benefit:** 75% = $482.70 85% = $550.35
Fee 41879	Tracheoplasty, laryngoplasty or thyroplasty, not by injection techniques, including tracheostomy, other than a service associated with a service to which item 41870 applies (H) (Anaes.) (Assist.) **Fee:** $1,042.80 **Benefit:** 75% = $782.10
Fee 41880	Tracheostomy by a percutaneous technique (H) (Anaes.) **Fee:** $278.30 **Benefit:** 75% = $208.75
Fee 41881	Tracheostomy by open exposure of the trachea (H) (Anaes.) (Assist.)

T8. SURGICAL OPERATIONS	8. EAR, NOSE AND THROAT
	Fee: $440.05 **Benefit:** 75% = $330.05
Fee 41884	Cricothyrostomy (H) (Anaes.) **Fee:** $99.70 **Benefit:** 75% = $74.80
Fee 41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $315.30 **Benefit:** 75% = $236.50 85% = $268.05
Fee 41886	TRACHEA, removal of foreign body in (Anaes.) **Fee:** $195.00 **Benefit:** 75% = $146.25 85% = $165.75
Fee 41887 S	Pituitary tumour, removal of, by trans-sphenoidal approach, including stereotaxy and dermis, dermofat or fascia grafting, as part of conjoint surgery, other than a service associated with a service to which item 40600 applies (H) (Anaes.) (Assist.) **Fee:** $2,958.85 **Benefit:** 75% = $2219.15
Fee 41888 S	Fractured skull, after trauma only, or spontaneous defects with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (H) (Anaes.) (Assist.) **Fee:** $2,094.10 **Benefit:** 75% = $1570.60
Fee 41890 S	Orbit, decompression of, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, one eye by endonasal approach (H) (Anaes.) (Assist.) **Fee:** $1,400.10 **Benefit:** 75% = $1050.10
Fee 41907	NASAL SEPTUM BUTTON, insertion of (Anaes.) **Fee:** $134.50 **Benefit:** 75% = $100.90 85% = $114.35
Fee 41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $427.40 **Benefit:** 75% = $320.55

T8. SURGICAL OPERATIONS	9. OPHTHALMOLOGY
	Group T8. Surgical Operations
	Subgroup 9. Ophthalmology
Fee 42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $112.25 **Benefit:** 75% = $84.20
Fee 42504 S	Glaucoma, implantation of a micro-bypass surgery stent system into the trabecular meshwork, if: (a) conservative therapies have failed, are likely to fail, or are contraindicated; and (b) the service is performed by a specialist with training that is recognised by the Conjoint Committee for the Recognition of Training in Micro-Bypass Glaucoma Surgery

	(Anaes.) (See para GN.5.16 of explanatory notes to this Category) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00 **Extended Medicare Safety Net Cap:** $49.45
Fee 42505	Complete removal from the eye of a trans-trabecular drainage device or devices, with or without replacement, following device related medical complications necessitating complete removal. (Anaes.) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00 **Extended Medicare Safety Net Cap:** $49.45
Fee 42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.) **Fee:** $527.05 **Benefit:** 75% = $395.30 85% = $448.00
Fee 42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.) **Fee:** $667.10 **Benefit:** 75% = $500.35
Fee 42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.) **Fee:** $768.90 **Benefit:** 75% = $576.70
Fee 42512	GLOBE, EVISCERATION OF (Anaes.) (Assist.) **Fee:** $527.05 **Benefit:** 75% = $395.30 85% = $448.00
Fee 42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.) **Fee:** $667.10 **Benefit:** 75% = $500.35
Fee 42518	ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayed procedure, or REMOVAL OF IMPLANT FROM SOCKET, or PLACEMENT OF A MOTILITY INTEGRATING PEG by drilling into an existing orbital implant (Anaes.) (Assist.) **Fee:** $387.05 **Benefit:** 75% = $290.30
Fee 42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) **Fee:** $1,317.80 **Benefit:** 75% = $988.35
Fee 42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.) **Fee:** $224.05 **Benefit:** 75% = $168.05 85% = $190.45
Fee 42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) **Fee:** $444.70 **Benefit:** 75% = $333.55

Fee 42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.) **Fee:** $691.90 **Benefit:** 75% = $518.95
Fee 42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.) **Fee:** $444.70 **Benefit:** 75% = $333.55
Fee 42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.) **Fee:** $914.05 **Benefit:** 75% = $685.55
Fee 42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.) **Fee:** $1,301.35 **Benefit:** 75% = $976.05
Fee 42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $551.90 **Benefit:** 75% = $413.95
Fee 42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $968.00 **Benefit:** 75% = $726.00
Fee 42545	ORBIT, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.) (Assist.) **Fee:** $1,400.10 **Benefit:** 75% = $1050.10
Fee 42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) **Fee:** $831.70 **Benefit:** 75% = $623.80
Fee 42551	EYE, PENETRATING WOUND OR RUPTURE OF, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.) (Assist.) **Fee:** $691.90 **Benefit:** 75% = $518.95 85% = $598.70
Fee 42554	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.) **Fee:** $807.20 **Benefit:** 75% = $605.40
Fee 42557	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) **Fee:** $1,128.30 **Benefit:** 75% = $846.25
Fee 42563	INTRAOCULAR FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.) **Fee:** $568.40 **Benefit:** 75% = $426.30 85% = $483.15
Fee 42569	INTRAOCULAR FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.) **Fee:** $1,128.30 **Benefit:** 75% = $846.25
Fee 42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes.) **Fee:** $128.55 **Benefit:** 75% = $96.45 85% = $109.30

Fee 42573	DERMOID, periorbital, excision of, on a patient 10 years of age or over (Anaes.) **Fee:** $249.10 **Benefit:** 75% = $186.85 85% = $211.75
Fee 42574	DERMOID, orbital, excision of (Anaes.) (Assist.) **Fee:** $529.30 **Benefit:** 75% = $397.00 85% = $449.95
Fee 42575	TARSAL CYST, extirpation of (Anaes.) **Fee:** $90.60 **Benefit:** 75% = $67.95 85% = $77.05
Fee 42576	DERMOID, periorbital, excision of, on a patient under 10 years of age (Anaes.) **Fee:** $323.85 **Benefit:** 75% = $242.90 85% = $275.30
Fee 42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.) **Fee:** $128.55 **Benefit:** 75% = $96.45 85% = $109.30
Fee 42584	TARSORRHAPHY (Anaes.) (Assist.) **Fee:** $303.15 **Benefit:** 75% = $227.40 85% = $257.70
Fee 42587	TRICHIASIS (due to causes other than trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $56.95 **Benefit:** 75% = $42.75 85% = $48.45
Fee 42588	TRICHIASIS (due to trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $56.95 **Benefit:** 75% = $42.75 85% = $48.45
Fee 42590	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.) **Fee:** $370.60 **Benefit:** 75% = $277.95 85% = $315.05 **Extended Medicare Safety Net Cap:** $296.50
Fee 42593	LACRIMAL GLAND, excision of palpebral lobe (Anaes.) **Fee:** $224.05 **Benefit:** 75% = $168.05
Fee 42596	LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.) **Fee:** $551.90 **Benefit:** 75% = $413.95 85% = $469.15
Fee 42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.) **Fee:** $691.90 **Benefit:** 75% = $518.95 85% = $598.70
Fee 42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.) **Fee:** $691.90 **Benefit:** 75% = $518.95 85% = $598.70
Fee 42605	LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.) **Fee:** $510.50 **Benefit:** 75% = $382.90 85% = $433.95
Fee 42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00

Fee 42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $105.40 **Benefit:** 75% = $79.05 85% = $89.60
Fee 42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $158.10 **Benefit:** 75% = $118.60 85% = $134.40
Fee 42614	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, unilateral, including lavage, not being a service associated with a service to which item 42610 applies (excluding aftercare) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $52.90 **Benefit:** 75% = $39.70 85% = $45.00
Fee 42615	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not being a service associated with a service to which item 42611 applies (excluding aftercare) **Fee:** $79.10 **Benefit:** 75% = $59.35 85% = $67.25
Fee 42617	PUNCTUM SNIP operation (Anaes.) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
Fee 42620	PUNCTUM, occlusion of, by use of a plug (Anaes.) **Fee:** $57.70 **Benefit:** 75% = $43.30 85% = $49.05
Fee 42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.) **Fee:** $90.60 **Benefit:** 75% = $67.95 85% = $77.05
Fee 42623	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.) **Fee:** $766.05 **Benefit:** 75% = $574.55
Fee 42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.) **Fee:** $1,235.50 **Benefit:** 75% = $926.65 85% = $1142.30
Fee 42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.) **Fee:** $930.65 **Benefit:** 75% = $698.00
Fee 42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.) **Fee:** $128.55 **Benefit:** 75% = $96.45 85% = $109.30
Fee 42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00
Fee 42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) **Fee:** $411.80 **Benefit:** 75% = $308.85 85% = $350.05
Fee 42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.)

	Fee: $535.30 **Benefit:** 75% = $401.50 85% = $455.05
Fee 42644	CORNEA OR SCLERA, complete removal of embedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) (Anaes.) (See para TN.8.78, TN.8.4 of explanatory notes to this Category) **Fee:** $79.00 **Benefit:** 75% = $59.25 85% = $67.15
Fee 42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.) **Fee:** $224.05 **Benefit:** 75% = $168.05 85% = $190.45
Fee 42650	CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $79.00 **Benefit:** 75% = $59.25 85% = $67.15
Fee 42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.) **Fee:** $176.10 **Benefit:** 75% = $132.10 85% = $149.70
Fee 42652	Corneal collagen cross linking, on a patient with a corneal ectatic disorder, with evidence of progression—per eye (Anaes.) (See para TN.8.136 of explanatory notes to this Category) **Fee:** $1,314.30 **Benefit:** 75% = $985.75 85% = $1221.10
Fee 42653	CORNEA transplantation of (Anaes.) (Assist.) **Fee:** $1,432.25 **Benefit:** 75% = $1074.20
Fee 42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.) **Fee:** $1,828.45 **Benefit:** 75% = $1371.35
Fee 42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) **Fee:** $988.20 **Benefit:** 75% = $741.15
Fee 42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.) **Fee:** $658.95 **Benefit:** 75% = $494.25 85% = $565.75
Fee 42667	RUNNING CORNEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to reduce astigmatism where a reduction of 2 dioptres of astigmatism is obtained, including any associated consultation **Fee:** $155.40 **Benefit:** 75% = $116.55 85% = $132.10
Fee 42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) **Fee:** $82.45 **Benefit:** 75% = $61.85 85% = $70.10
Fee 42672	CORNEAL INCISONS, to correct corneal astigmatism of more than $1^{1/}_{2}$ dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.) (See para TN.8.79 of explanatory notes to this Category) **Fee:** $988.20 **Benefit:** 75% = $741.15 85% = $895.00

Fee 42673	ADDITIONAL CORNEAL INCISIONS, to correct corneal astigmatism of more than $1^1/_2$ dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.) **Fee:** $494.00 **Benefit:** 75% = $370.50 85% = $419.90
Fee 42676	CONJUNCTIVA, biopsy of, as an independent procedure **Fee:** $126.70 **Benefit:** 75% = $95.05 85% = $107.70
Fee 42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.) **Fee:** $66.75 **Benefit:** 75% = $50.10 85% = $56.75
Fee 42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO^2 or N^20 (Anaes.) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00
Fee 42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) **Fee:** $131.85 **Benefit:** 75% = $98.90
Fee 42686	PTERYGIUM, removal of (Anaes.) **Fee:** $299.70 **Benefit:** 75% = $224.80 85% = $254.75
Fee 42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) **Fee:** $128.55 **Benefit:** 75% = $96.45 85% = $109.30
Fee 42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) **Fee:** $303.15 **Benefit:** 75% = $227.40 85% = $257.70
Fee 42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) **Fee:** $494.00 **Benefit:** 75% = $370.50 85% = $419.90
Fee 42698	LENS EXTRACTION, excluding surgery performed for the correction of refractive error *except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye* (Anaes.) (See para TN.8.80 of explanatory notes to this Category) **Fee:** $651.35 **Benefit:** 75% = $488.55 85% = $558.15
Fee 42701	INTRAOCULAR LENS, insertion of, excluding surgery performed for the correction of refractive error *except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye* (Anaes.) (See para TN.8.80 of explanatory notes to this Category) **Fee:** $363.25 **Benefit:** 75% = $272.45 85% = $308.80
Fee 42702	LENS EXTRACTION AND INSERTION OF INTRAOCULAR LENS, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.) **Fee:** $833.05 **Benefit:** 75% = $624.80 85% = $739.85 **Extended Medicare Safety Net Cap:** $125.00

Fee 42703	INTRAOCULAR LENS or IRIS PROSTHESIS insertion of, into the posterior chamber with fixation to the iris or sclera (Anaes.) (Assist.) **Fee:** $626.45 **Benefit:** 75% = $469.85 85% = $533.25
Fee 42704	INTRAOCULAR LENS, REMOVAL or REPOSITIONING of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.) **Fee:** $510.50 **Benefit:** 75% = $382.90 85% = $433.95
Fee 42705	LENS EXTRACTION AND INSERTION OF INTRAOCULAR LENS, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye, performed in association with insertion of a trans-trabecular drainage device or devices, in a patient diagnosed with open angle glaucoma who is not adequately responsive to topical anti-glaucoma medications or who is intolerant of anti-glaucoma medication. (Anaes.) **Fee:** $997.90 **Benefit:** 75% = $748.45 85% = $904.70 **Extended Medicare Safety Net Cap:** $149.70
Fee 42707	INTRAOCULAR LENS, REMOVAL of and REPLACEMENT with a different lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.) **Fee:** $873.00 **Benefit:** 75% = $654.75 85% = $779.80
Fee 42710	INTRAOCULAR LENS, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Anaes.) (Assist.) **Fee:** $988.20 **Benefit:** 75% = $741.15 85% = $895.00
Fee 42713	IRIS SUTURING, McCannell technique or similar, for fixation of intraocular lens or repair of iris defect (Anaes.) (Assist.) **Fee:** $411.80 **Benefit:** 75% = $308.85 85% = $350.05
Fee 42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.) **Fee:** $1,309.55 **Benefit:** 75% = $982.20 85% = $1216.35
Fee 42719	REMOVAL OF VITREOUS, and/or CAPSULAR or LENS MATERIAL, via a limbal approach, not being a service associated with a service to which item 42698, 42702, 42716, 42725 or 42731 applies (Anaes.) (Assist.) **Fee:** $568.40 **Benefit:** 75% = $426.30 85% = $483.15
Fee 42725	Vitrectomy via pars plana sclerotomy, including one or more of the following: (a) removal of vitreous; (b) division of vitreous bands; (c) removal of epiretinal membranes; (d) capsulotomy (Anaes.) (Assist.) **Fee:** $1,465.90 **Benefit:** 75% = $1099.45
Fee 42731	LIMBAL OR PARS PLANA LENSECTOMY combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Anaes.) (Assist.)

	Fee: $1,663.65 **Benefit:** 75% = $1247.75
Fee 42734	Capsulotomy, other than by laser, and other than a service associated with a service to which item 42725 or 42731 applies (Anaes.) (Assist.) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00
Fee 42738	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure. (See para TN.8.121 of explanatory notes to this Category) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00 **Extended Medicare Safety Net Cap:** $263.55
Fee 42739	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, one or more of, as an independent procedure, for a patient requiring the administration of anaesthetic by an anaesthetist. (Anaes.) (See para TN.8.121 of explanatory notes to this Category) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00 **Extended Medicare Safety Net Cap:** $263.55
Fee 42740	INTRAVITREAL INJECTION OF THERAPEUTIC SUBSTANCES, or the removal of vitreous humour for diagnostic purposes, 1 or more of, as a procedure associated with other intraocular surgery. (Anaes.) (See para TN.8.121 of explanatory notes to this Category) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00 **Extended Medicare Safety Net Cap:** $263.55
Fee 42741	Posterior juxtascleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, 1 or more of (Anaes.) (See para TN.8.81 of explanatory notes to this Category) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00
Fee 42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.) **Fee:** $691.90 **Benefit:** 75% = $518.95 85% = $598.70
Fee 42744	Needle revision of glaucoma filtration bleb, following glaucoma filtering procedure (Anaes.) **Fee:** $329.20 **Benefit:** 75% = $246.90 85% = $279.85
Fee 42746	GLAUCOMA, filtering operation for, where conservative therapies have failed, are likely to fail, or are contraindicated (Anaes.) (Assist.) **Fee:** $1,045.95 **Benefit:** 75% = $784.50
Fee 42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.) **Fee:** $1,309.55 **Benefit:** 75% = $982.20
Fee 42752	GLAUCOMA, insertion of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) (Assist.) (See para TN.8.83 of explanatory notes to this Category) **Fee:** $1,465.90 **Benefit:** 75% = $1099.45

Fee 42755	GLAUCOMA, removal of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) **Fee:** $181.20 **Benefit:** 75% = $135.90 85% = $154.05
Fee 42758	Goniotomy for the treatment of primary congenital glaucoma, excluding the minimally invasive implantation of glaucoma drainage devices (Anaes.) (Assist.) **Fee:** $766.05 **Benefit:** 75% = $574.55
Fee 42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $568.40 **Benefit:** 75% = $426.30 85% = $483.15
Fee 42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $568.40 **Benefit:** 75% = $426.30 85% = $483.15
Fee 42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) **Fee:** $1,194.15 **Benefit:** 75% = $895.65
Fee 42770	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para TN.8.82 of explanatory notes to this Category) **Fee:** $322.85 **Benefit:** 75% = $242.15 85% = $274.45
Fee 42773	DETACHED RETINA, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.) **Fee:** $988.20 **Benefit:** 75% = $741.15 85% = $895.00
Fee 42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) **Fee:** $1,465.90 **Benefit:** 75% = $1099.45
Fee 42779	DETACHED RETINA, revision of scleral buckling operation for (Anaes.) (Assist.) **Fee:** $1,828.45 **Benefit:** 75% = $1371.35
Fee 42782	LASER TRABECULOPLASTY, for the treatment of glaucoma. Each treatment to 1 eye, to a maximum 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:** $494.00 **Benefit:** 75% = $370.50 85% = $419.90
Fee 42785	LASER IRIDOTOMY - each treatment episode to 1 eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para TN.8.85 of explanatory notes to this Category) **Fee:** $387.05 **Benefit:** 75% = $290.30 85% = $329.00
Fee 42788	Laser capsulotomy—each treatment episode to one eye, to a maximum of 2 treatments to that eye in a 2 year period—other than a service associated with a service to which item 42702 applies (Anaes.) (Assist.) (See para TN.8.86 of explanatory notes to this Category) **Fee:** $387.05 **Benefit:** 75% = $290.30 85% = $329.00

Fee 42791	Laser vitreolysis or corticolysis of lens material or fibrinolysis, excluding vitreolysis in the posterior vitreous cavity—each treatment to one eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para TN.8.87 of explanatory notes to this Category) **Fee:** $387.05 **Benefit:** 75% = $290.30 85% = $329.00
Fee 42794	DIVISION OF SUTURE BY LASER following glaucoma filtration surgery, each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (See para TN.8.88 of explanatory notes to this Category) **Fee:** $74.20 **Benefit:** 75% = $55.65 85% = $63.10
Fee 42801	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.) **Fee:** $1,149.70 **Benefit:** 75% = $862.30
Fee 42802	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.) **Fee:** $574.65 **Benefit:** 75% = $431.00
Fee 42805	TANTALUM MARKERS, surgical insertion to the sclera to localise the tumour base to assist in planning of radiotherapy of choroidal melanomas, 1 or more (Anaes.) (Assist.) **Fee:** $642.35 **Benefit:** 75% = $481.80 85% = $549.15
Fee 42806	IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.) **Fee:** $387.05 **Benefit:** 75% = $290.30 85% = $329.00
Fee 42807	PHOTOMYDRIASIS, laser **Fee:** $389.65 **Benefit:** 75% = $292.25 85% = $331.25
Fee 42808	Laser peripheral iridoplasty **Fee:** $389.65 **Benefit:** 75% = $292.25 85% = $331.25
Fee 42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) **Fee:** $494.00 **Benefit:** 75% = $370.50 85% = $419.90
Fee 42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.) **Fee:** $621.75 **Benefit:** 75% = $466.35 85% = $528.55
Fee 42811	TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.) **Fee:** $494.00 **Benefit:** 75% = $370.50 85% = $419.90
Fee 42812	Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.) **Fee:** $181.20 **Benefit:** 75% = $135.90 85% = $154.05
Fee 42815	VITREOUS CAVITY, removal of silicone oil or other liquid vitreous substitutes from, during a procedure other than that in which the vitreous substitute is inserted (Anaes.) (Assist.)

	Fee: $691.90 **Benefit:** 75% = $518.95
Fee 42818	RETINA, CRYOTHERAPY TO, as an independent procedure, or when performed in conjunction with item 42809 or 42770 (Anaes.) **Fee:** $642.35 **Benefit:** 75% = $481.80 85% = $549.15
Fee 42821	OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
Fee 42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure **Fee:** $76.50 **Benefit:** 75% = $57.40 85% = $65.05
Fee 42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $642.35 **Benefit:** 75% = $481.80
Fee 42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $798.85 **Benefit:** 75% = $599.15
Fee 42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $766.05 **Benefit:** 75% = $574.55
Fee 42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 or MORE MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $955.35 **Benefit:** 75% = $716.55
Fee 42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.) (See para TN.8.89 of explanatory notes to this Category) **Fee:** $207.45 **Benefit:** 75% = $155.60 85% = $176.35
Fee 42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $766.05 **Benefit:** 75% = $574.55
Fee 42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $955.35 **Benefit:** 75% = $716.55
Fee 42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.) **Fee:** $444.70 **Benefit:** 75% = $333.55 85% = $378.00

Fee 42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.) **Fee:** $444.70 **Benefit:** 75% = $333.55 85% = $378.00
Fee 42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.) **Fee:** $988.20 **Benefit:** 75% = $741.15 85% = $895.00
Fee 42863	EYELID, recession of (Anaes.) (Assist.) **Fee:** $848.35 **Benefit:** 75% = $636.30 85% = $755.15
Fee 42866	ENTROPION or TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.) **Fee:** $823.45 **Benefit:** 75% = $617.60 85% = $730.25
Fee 42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) **Fee:** $601.30 **Benefit:** 75% = $451.00 85% = $511.15
Fee 42872	EYEBROW, elevation of, by skin excision, to correct for a reduced field of vision caused by paretic, involutional, or traumatic eyebrow descent/ptosis to a position below the superior orbital rim (Anaes.) **Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10
Fee 43021	Photodynamic therapy, one eye, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation. **Fee:** $498.40 **Benefit:** 75% = $373.80 85% = $423.65
Fee 43022	Photodynamic therapy, both eyes, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation. **Fee:** $598.15 **Benefit:** 75% = $448.65 85% = $508.45
Fee 43023	Infusion of Verteporfin for discontinued photodynamic therapy, where a session of therapy which would have been provided under item 43021 or 43022 has been discontinued on medical grounds. **Fee:** $96.85 **Benefit:** 75% = $72.65 85% = $82.35

	Group T8. Surgical Operations
	Subgroup 10. Operations For Osteomyelitis
	CHRONIC
Fee 43521	OPERATION ON SKULL (Anaes.) (Assist.) **Fee:** $508.80 **Benefit:** 75% = $381.60
Fee 43527	Operation on sternum, clavicle, rib, metacarpus, carpus, phalanx, metatarsus, tarsus, mandible or maxilla (other than alveolar margins), by open or arthroscopic means, for septic arthritis or osteomyelitis—one approach, inclusive of the adjoining joint (H) (Anaes.) (Assist.)

T8. SURGICAL OPERATIONS	10. OPERATIONS FOR OSTEOMYELITIS
	Fee: $390.30 **Benefit:** 75% = $292.75
Fee 43530	Operation on scapula, ulna, radius, tibia, fibula, humerus or femur, by open or arthroscopic means, for septic arthritis or osteomyelitis—one approach, inclusive of the adjoining joint (Anaes.) (Assist.) **Fee:** $390.30 **Benefit:** 75% = $292.75 85% = $331.80
Fee 43533	Operation on spine or pelvic bones, by open or arthroscopic means, for septic arthritis or osteomyelitis—one approach, inclusive of the adjoining joint (Anaes.) (Assist.) **Fee:** $643.55 **Benefit:** 75% = $482.70 85% = $550.35

T8. SURGICAL OPERATIONS	11. PAEDIATRIC
	Group T8. Surgical Operations
	Subgroup 11. Paediatric
	SURGERY IN NEONATE OR YOUNG CHILD
Fee 43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) **Fee:** $1,048.50 **Benefit:** 75% = $786.40
Fee 43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.) **Fee:** $1,116.30 **Benefit:** 75% = $837.25
Fee 43805	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, on a patient under 10 years of age (Anaes.) **Fee:** $390.30 **Benefit:** 75% = $292.75
Fee 43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.) **Fee:** $1,217.85 **Benefit:** 75% = $913.40
Fee 43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.) **Fee:** $1,420.85 **Benefit:** 75% = $1065.65
Fee 43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.) **Fee:** $1,420.85 **Benefit:** 75% = $1065.65
Fee 43816	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.) **Fee:** $1,319.30 **Benefit:** 75% = $989.50
Fee 43819	Agangliosis Coli, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) **Fee:** $1,065.65 **Benefit:** 75% = $799.25
Fee 43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.)

	Fee: $1,065.65 **Benefit:** 75% = $799.25
Fee 43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $1,217.85 **Benefit:** 75% = $913.40
Fee 43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,345.50 **Benefit:** 75% = $1009.15
Fee 43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.) **Fee:** $1,048.50 **Benefit:** 75% = $786.40
Fee 43832	Branchial fistula, removal of, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $715.10 **Benefit:** 75% = $536.35
Fee 43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,217.85 **Benefit:** 75% = $913.40
Fee 43835	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $742.25 **Benefit:** 75% = $556.70
Fee 43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.) **Fee:** $1,522.30 **Benefit:** 75% = $1141.75
Fee 43838	Diaphragmatic hernia, congential repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $1,362.95 **Benefit:** 75% = $1022.25
Fee 43840	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes.) (Assist.) **Fee:** $1,319.30 **Benefit:** 75% = $989.50
Fee 43841	Femoral or inguinal hernia or infantile hydrocele, repair of, on a patient under 10 years of age, other than a service to which item 30651 or 43835 applies (H) (Anaes.) (Assist.) **Fee:** $661.35 **Benefit:** 75% = $496.05
Fee 43843	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes.) (Assist.) **Fee:** $2,029.85 **Benefit:** 75% = $1522.40
Fee 43846	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes.) (Assist.) **Fee:** $2,182.00 **Benefit:** 75% = $1636.50
Fee 43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) **Fee:** $558.20 **Benefit:** 75% = $418.65

Fee 43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) **Fee:** $1,775.95 **Benefit:** 75% = $1332.00
Fee 43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) **Fee:** $1,877.65 **Benefit:** 75% = $1408.25
Fee 43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) **Fee:** $659.65 **Benefit:** 75% = $494.75
Fee 43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) **Fee:** $1,826.90 **Benefit:** 75% = $1370.20
Fee 43864	GASTROSCHISIS, operation for (Anaes.) (Assist.) **Fee:** $1,370.15 **Benefit:** 75% = $1027.65
Fee 43867	GASTROSCHISIS or Exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.) **Fee:** $761.15 **Benefit:** 75% = $570.90
Fee 43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) **Fee:** $1,065.65 **Benefit:** 75% = $799.25
Fee 43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) **Fee:** $1,420.85 **Benefit:** 75% = $1065.65
Fee 43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) **Fee:** $1,217.85 **Benefit:** 75% = $913.40
Fee 43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) **Fee:** $1,420.85 **Benefit:** 75% = $1065.65
Fee 43882	Cloacal exstrophy, operation for (H) (Anaes.) (Assist.) **Fee:** $1,826.90 **Benefit:** 75% = $1370.20
	THORACIC SURGERY
Fee 43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) **Fee:** $1,217.85 **Benefit:** 75% = $913.40
Fee 43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) **Fee:** $2,029.85 **Benefit:** 75% = $1522.40
Fee 43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) **Fee:** $1,775.95 **Benefit:** 75% = $1332.00
Fee 43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.)

	Fee: $1,775.95 **Benefit:** 75% = $1332.00
Fee 43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) **Fee:** $1,677.85 **Benefit:** 75% = $1258.40
Fee 43915	EVENTRATION, plication of diaphragm for (Anaes.) (Assist.) **Fee:** $1,268.65 **Benefit:** 75% = $951.50
	ABDOMINAL SURGERY
Fee 43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) **Fee:** $487.85 **Benefit:** 75% = $365.90
Fee 43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) **Fee:** $571.10 **Benefit:** 75% = $428.35
Fee 43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) **Fee:** $1,065.65 **Benefit:** 75% = $799.25
Fee 43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.) **Fee:** $811.90 **Benefit:** 75% = $608.95
Fee 43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.) **Fee:** $253.75 **Benefit:** 75% = $190.35
Fee 43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) **Fee:** $1,065.65 **Benefit:** 75% = $799.25
Fee 43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.) **Fee:** $152.35 **Benefit:** 75% = $114.30
Fee 43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) **Fee:** $954.30 **Benefit:** 75% = $715.75
Fee 43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,167.25 **Benefit:** 75% = $875.45
Fee 43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,268.65 **Benefit:** 75% = $951.50
Fee 43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.) **Fee:** $446.30 **Benefit:** 75% = $334.75
Fee 43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.) **Fee:** $1,775.95 **Benefit:** 75% = $1332.00

Fee 43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.) **Fee:** $2,029.85 **Benefit:** 75% = $1522.40
Fee 43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.) **Fee:** $2,791.05 **Benefit:** 75% = $2093.30
Fee 43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.) **Fee:** $2,029.85 **Benefit:** 75% = $1522.40
Fee 43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $2,385.10 **Benefit:** 75% = $1788.85
Fee 43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.) **Fee:** $2,029.85 **Benefit:** 75% = $1522.40
Fee 43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $558.20 **Benefit:** 75% = $418.65
Fee 43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.) **Fee:** $1,420.85 **Benefit:** 75% = $1065.65
Fee 43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.) **Fee:** $1,573.20 **Benefit:** 75% = $1179.90
Fee 43990	Aganglionosis Coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.) **Fee:** $1,928.40 **Benefit:** 75% = $1446.30
Fee 43993	Aganglionosis Coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Anaes.) (Assist.) **Fee:** $2,080.60 **Benefit:** 75% = $1560.45
Fee 43996	Aganglionosis Coli, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.) **Fee:** $2,334.35 **Benefit:** 75% = $1750.80
Fee 43999	Aganglionosis Coli, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) **Fee:** $291.90 **Benefit:** 75% = $218.95
Fee 44101	RECTUM, examination of, on a patient under 2 years of age, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) **Fee:** $365.85 **Benefit:** 75% = $274.40
Fee 44102	RECTUM, examination of, on a patient 2 years of age or over, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.)

	Fee: $281.45 **Benefit:** 75% = $211.10
Fee 44104	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a patient under 2 years of age, under general anaesthesia (Anaes.) **Fee:** $64.30 **Benefit:** 75% = $48.25 85% = $54.70
Fee 44105	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a patient 2 years of age or over, under general anaesthesia (Anaes.) **Fee:** $49.35 **Benefit:** 75% = $37.05 85% = $41.95
Fee 44108	Inguinal hernia, laparoscopic or open repair of, at age less than 12 months (H) (Anaes.) (Assist.) **Fee:** $661.35 **Benefit:** 75% = $496.05
Fee 44111	Obstructed or strangulated inguinal hernia, laparoscopic or open repair of, at age less than 12 months, including orchidopexy when performed (H) (Anaes.) (Assist.) **Fee:** $742.25 **Benefit:** 75% = $556.70
Fee 44114	Inguinal hernia, laparoscopic or open repair of, at age less than 12 months when orchidopexy also required (H) (Anaes.) (Assist.) **Fee:** $742.25 **Benefit:** 75% = $556.70
	MISCELLANEOUS SURGERY
Fee 44130	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) **Fee:** $507.40 **Benefit:** 75% = $380.55 85% = $431.30
Fee 44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) **Fee:** $402.75 **Benefit:** 75% = $302.10
Fee 44136	INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes.) **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80

	Group T8. Surgical Operations
	Subgroup 12. Amputations
Fee 44325	Amputation of hand, transcarpal (H) (Anaes.) (Assist.) **Fee:** $323.85 **Benefit:** 75% = $242.90
Fee 44328	Amputation of hand, proximal to wrist radiocarpal joint, through forearm (H) (Anaes.) (Assist.) **Fee:** $390.30 **Benefit:** 75% = $292.75
Fee 44331	AMPUTATION AT SHOULDER (Anaes.) (Assist.) **Fee:** $643.55 **Benefit:** 75% = $482.70
Fee 44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.) **Fee:** $1,308.00 **Benefit:** 75% = $981.00 85% = $1214.80

Fee 44338	Amputation of one digit of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.) **Fee:** $157.75 **Benefit:** 75% = $118.35
Fee 44342	Amputation of 2 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.) **Fee:** $240.85 **Benefit:** 75% = $180.65
Fee 44346	Amputation of 3 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.) **Fee:** $278.15 **Benefit:** 75% = $208.65
Fee 44350	Amputation of 4 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.) **Fee:** $315.60 **Benefit:** 75% = $236.70
Fee 44354	Amputation of 5 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma;

	(c) skin cover with homodigital flaps (H) (Anaes.) (Assist.) **Fee:** $361.25 **Benefit:** 75% = $270.95
Fee 44358	Amputation of one ray of one foot, proximal to the metatarsal head, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover or recontouring with homodigital flaps (H) (Anaes.) (Assist.) **Fee:** $240.85 **Benefit:** 75% = $180.65
Fee 44359	Amputation of one or more toes of one foot, or amputation at midfoot or hindfoot of one foot, for diabetic or other microvascular disease; (a) including any of the following (if performed): (i) resection of bone; (ii) excision of neuromas; (iii) excision of one or more bones of the foot; (iv) treatment of underlying infection; (v) skin cover or recontouring with homodigital flaps; and (b) excluding aftercare; —applicable only once per foot per occasion on which the service is performed (H) (Anaes.) (Assist.) **Fee:** $289.05 **Benefit:** 75% = $216.80
Fee 44361	Amputation of foot, at ankle or hindfoot, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover; (H) (Anaes.) (Assist.) **Fee:** $477.95 **Benefit:** 75% = $358.50
Fee 44364	Amputation of foot, transtarsal, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas;

	(c) skin cover; (H) (Anaes.) (Assist.) **Fee:** $323.85 **Benefit:** 75% = $242.90
Fee 44367	Amputation through thigh, at knee or below knee (H) (Anaes.) (Assist.) **Fee:** $571.65 **Benefit:** 75% = $428.75
Fee 44370	AMPUTATION AT HIP (Anaes.) (Assist.) **Fee:** $788.80 **Benefit:** 75% = $591.60
Fee 44373	HINDQUARTER, amputation of (Anaes.) (Assist.) **Fee:** $1,619.15 **Benefit:** 75% = $1214.40 85% = $1525.95
44376	Amputation stump, re-amputation of, to provide adequate skin and muscle cover (Anaes.) (Assist.) **Derived Fee:** 75% of the original amputation fee

	Group T8. Surgical Operations
	Subgroup 13. Plastic And Reconstructive Surgery
New 45440	Split thickness skin graft to a small defect that is: (a) less than 40 mm in diameter: (i) on areas below the knee; or (ii) distal to the ulnar styloid; or (iii) on the genital area; or (iv) on areas above the clavicle; or (b) less than 80 mm in diameter on any other part of the body (Anaes.) (Assist.) (See para TN.8.266 of explanatory notes to this Category) **Fee:** $311.45 **Benefit:** 75% = $233.60 85% = $264.75
New 45443	Split thickness skin graft to a large defect that is: (a) 40 mm or more in diameter: (i) on areas below the knee; or (ii) distal to the ulnar styloid; or (iii) on the genital area; or (iv) on areas above the clavicle; or (b) 80 mm or more in diameter on any other part of the body (Anaes.) (Assist.) (See para TN.8.266 of explanatory notes to this Category) **Fee:** $642.35 **Benefit:** 75% = $481.80 85% = $549.15

New 45507	Microvascular repair using microsurgical techniques, with restoration of continuity of artery and vein of distal extremity or digit, including anastomoses of all required vessels for that extremity or digit, other than a service associated with a service to which item 45564, 45565 or 45567 applies (H) (Anaes.) (Assist.) **Fee:** $1,791.25 **Benefit:** 75% = $1343.45
New 45510	Scar, of face or neck, not more than 3 cm in length, revision of, if: (a) undertaken in the operating theatre of a hospital; or (b) performed by a specialist in the practice of the specialist's specialty (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $240.85 **Benefit:** 75% = $180.65 85% = $204.75
New 45529	Breast reconstruction (bilateral), following mastectomy, using permanent prostheses, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) (See para TN.8.97 of explanatory notes to this Category) **Fee:** $2,053.10 **Benefit:** 75% = $1539.85
New 45531	Post-mastectomy breast reconstruction, autologous (bilateral), using a large muscle or myocutaneous flap, isolated on its vascular pedicle, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45006 or 45012 applies (H) (Anaes.) (Assist.) (See para TN.8.97, TN.8.8 of explanatory notes to this Category) **Fee:** $2,107.15 **Benefit:** 75% = $1580.40
New 45532	Revision of post-mastectomy breast reconstruction, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $296.65 **Benefit:** 75% = $222.50
New 45537	Perforator flap, such as a thoracodorsal artery perforator (TDAP) flap or a lateral intercostal artery perforator (LICAP) flap, or similar, raising on a named source vessel, for reconstruction of a partial mastectomy defect, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $861.50 **Benefit:** 75% = $646.15
New 45538	Perforator flap, such as a deep inferior epigastric perforator (DIEP) flap or similar, raising in preparation for microsurgical transfer of a free flap for post mastectomy breast reconstruction, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $985.70 **Benefit:** 75% = $739.30
New 45540	Breast reconstruction (bilateral), following mastectomy, using tissue expansion—insertion of tissue expansion unit and all attendances for subsequent expansion injections, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $2,763.80 **Benefit:** 75% = $2072.85
New 45541	Breast reconstruction (bilateral), following mastectomy, using tissue expansion—removal of tissue expansion unit and insertion of permanent prosthesis, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $1,175.65 **Benefit:** 75% = $881.75
New 45547	Revision of breast prosthesis pocket, if: (a) breast prosthesis or tissue expander has been placed for the purpose of breast reconstruction in the

	context of breast cancer or for developmental breast abnormality; and (b) the prosthesis or tissue expander has migrated or rotated from its intended position or orientation; and (c) the existing prosthesis is used (H) (Anaes.) (Assist.) (See para TN.8.262 of explanatory notes to this Category) **Fee:** $766.05 **Benefit:** 75% = $574.55
New 45567	Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) anastomoses of all required vessels; and (b) raising of tissue on a vascular pedicle; and (c) preparation of recipient vessels; and (d) transfer of tissue; and (e) insetting of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562, 45564 or 45565 applies—single surgeon (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $3,216.55 **Benefit:** 75% = $2412.45
New 45571	Closure of abdomen with reconstruction of umbilicus, with or without lipectomy, to be used following the harvest of an autologous flap, being a service associated with a service to which item 45530, 45531, 45562, 45564, 45565 or 45567 applies, including repair of the musculoaponeurotic layer of the abdomen (including insertion of prosthetic mesh if used) (H) (Anaes.) (Assist.) (See para TN.8.97, TN.8.8 of explanatory notes to this Category) **Fee:** $1,133.55 **Benefit:** 75% = $850.20
New 45592	Orbital cavity, reconstruction of wall and floor with bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 45594 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $932.25 **Benefit:** 75% = $699.20
New 45594	Orbital cavity, exploration of wall or floor without bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 45590 or 45592 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $436.90 **Benefit:** 75% = $327.70
New 45717	Alveolar cleft (congenital), unilateral, bone grafting of, including local flap closure of associated oro-nasal fistulae and ridge augmentation, other than a service associated with a service to which item 45718 applies (H) (Anaes.) (Assist.) **Fee:** $1,287.95 **Benefit:** 75% = $966.00
New 45718	Face, contour restoration of one region, for the correction of deformity using autogenous bone or cartilage, if the deformity: (a) is secondary to congenital absence of tissue; or (b) has arisen from: (i) trauma (other than from previous cosmetic surgery); or (ii) a diagnosed pathological process;

	other than a service associated with a service to which item 45644 or 45717 (alveolar bone grafting) applies (H) (Anaes.) (Assist.) (See para TN.8.105 of explanatory notes to this Category) **Fee:** $1,401.25 **Benefit:** 75% = $1050.95
New 45874	Temporomandibular joint, including condylar head and glenoid fossa, total alloplastic replacement (H) (Anaes.) (Assist.) **Fee:** $1,443.35 **Benefit:** 75% = $1082.55
New 46050	Perforator flap, raising on a named source vessel, for pedicled transfer for head or neck or other non-breast reconstruction (H) (Anaes.) (Assist.) (See para TN.8.268 of explanatory notes to this Category) **Fee:** $861.50 **Benefit:** 75% = $646.15
New 46052	Perforator Flap, such as anterolateral thigh flap or similar, raising in preparation for microsurgical transfer of a free flap for head or neck or other non-breast reconstruction (H) (Anaes.) (Assist.) (See para TN.8.268 of explanatory notes to this Category) **Fee:** $271.90 **Benefit:** 75% = $203.95
New 46060	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Single surgeon (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $2,915.50 **Benefit:** 75% = $2186.65
New 46062	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category)

	Fee: $2,788.80 **Benefit:** 75% = $2091.60
New 46064	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $2,091.70 **Benefit:** 75% = $1568.80
New 46066	Double free flap, including one free transfer of tissue with a vascularized bone component, for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $4,183.15 **Benefit:** 75% = $3137.40
New 46068	Double free flap, including one free transfer of tissue with a vascularized bone component, for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $3,137.55 **Benefit:** 75% = $2353.20

New 46070	Double free flap, including 2 free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques, all necessary elements of the operation, including (but not limited to): (a) raising each flap of tissue on a separate vascular pedicle; and (b) preparation of recipient vessels; and (c) transfer of tissue; and (d) inset of tissue at recipient site; and (e) direct repair of secondary cutaneous defect, if performed; other than a service: (f) performed in the context of breast reconstruction; or (g) associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $4,183.15 **Benefit:** 75% = $3137.40
New 46072	Double free flap, including 2 free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) raising each flap of tissue on a separate vascular pedicle; and (b) preparation of recipient vessels; and (c) transfer of tissue; and (d) inset of tissue at recipient site; and (e) direct repair of secondary cutaneous defect, if performed; other than a service: (f) performed in the context of breast reconstruction; or (g) associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $3,137.55 **Benefit:** 75% = $2353.20
New 46080	Post-mastectomy breast reconstruction, autologous, single surgeon (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies (H) (Anaes.) (Assist.) **Fee:** $3,216.55 **Benefit:** 75% = $2412.45
New 46082	Post-mastectomy breast reconstruction, autologous, single surgeon (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomoses of arteries and veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies (H) (Anaes.) (Assist.) **Fee:** $5,629.00 **Benefit:** 75% = $4221.75
New 46084	Post-mastectomy breast reconstruction, autologous, conjoint surgery (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer;

	other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $2,788.80 **Benefit:** 75% = $2091.60
New 46086	Post-mastectomy breast reconstruction, autologous, conjoint surgery (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $2,091.70 **Benefit:** 75% = $1568.80
New 46088	Post-mastectomy breast reconstruction, autologous, conjoint surgery (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $4,880.35 **Benefit:** 75% = $3660.30
New 46090	Post-mastectomy breast reconstruction, autologous, conjoint surgery (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomoses of arteries and veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $3,660.40 **Benefit:** 75% = $2745.30
New 46092	Lower pole coverage of reconstructive breast prosthesis, following mastectomy, using muscle or fascia turnover flap or autologous dermal flaps, if the service is performed in combination with a service to which item 31522, 31523, 31528, 31529, 45527, 45539 or 45542 applies (Anaes.) (Assist.) (See para TN.8.272 of explanatory notes to this Category) **Fee:** $444.70 **Benefit:** 75% = $333.55 85% = $378.00
New 46094	Lower pole coverage or complete implant coverage of reconstructive breast prosthesis, following mastectomy, using allograft or synthetic products (Anaes.) (Assist.) (See para TN.8.272 of explanatory notes to this Category) **Fee:** $328.55 **Benefit:** 75% = $246.45 85% = $279.30
New 46100	Excision of burnt tissue, or definitive burn wound closure, if: (a) the area of burn excised involves more than 1% of hands, face or anterior neck; and (b) the service is performed in conjunction with a service (the co-claimed service) to which any of items 46101 to 46135 (other than item 46112 or 46124) apply; other than a service to which item 46136 applies (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Derived Fee:** 40% of the fee for the co-claimed service - performed in conjunction with a service (the co-claimed service) to which any of items 46101 to 46135 (other than item 46112 or 46124) apply.

New 46101	Excision of burnt tissue, if the area of burn excised involves not more than 1% of the total body surface (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $369.65 **Benefit:** 75% = $277.25 85% = $314.25
New 46102	Excision of burnt tissue, if the area of burn excised involves more than 1% but less than 3% of the total body surface (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $586.80 **Benefit:** 75% = $440.10
New 46103	Excision of burnt tissue, if the area of burn excised involves 3% or more but less than 10% of the total body surface (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $643.65 **Benefit:** 75% = $482.75
New 46104	Excision of burnt tissue, if the area of burn excised involves 10% or more but less than 20% of the total body surface, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $981.95 **Benefit:** 75% = $736.50
New 46105	Excision of burnt tissue, if the area of burn excised involves 20% or more but less than 30% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,320.60 **Benefit:** 75% = $990.45
New 46106	Excision of burnt tissue, if the area of burn excised involves 30% or more but less than 40% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,659.80 **Benefit:** 75% = $1244.85
New 46107	Excision of burnt tissue, if the area of burn excised involves 40% or more but less than 50% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,998.45 **Benefit:** 75% = $1498.85
New 46108	Excision of burnt tissue, if the area of burn excised involves 50% or more but less than 60% of total body surface (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274, TN.8.275 of explanatory notes to this Category) **Fee:** $2,336.50 **Benefit:** 75% = $1752.40
New 46109	Excision of burnt tissue, if the area of burn excised involves 60% or more but less than 70% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,675.20 **Benefit:** 75% = $2006.40
New 46110	Excision of burnt tissue, if the area of burn excised involves 70% or more but less than 80% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $3,048.05 **Benefit:** 75% = $2286.05

New 46111	Excision of burnt tissue, if the area of burn excised involves 80% or more of total body surface, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $3,413.65 **Benefit:** 75% = $2560.25
New 46112	Excision of burnt tissue, if the area of burn excised involves whole of face (excluding ears)—may be claimed with any one of items 46101 to 46111, based on the percentage total body surface (excluding the face), other than a service associated with a service to which item 46100 applies and excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,884.50 **Benefit:** 75% = $1413.40
New 46113	Excised burn wound closure, or closure of skin defect secondary to burns contracture release, if the defect area is not more than 1% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $369.65 **Benefit:** 75% = $277.25 85% = $314.25
New 46114	Excised burn wound closure, or closure of skin defect secondary to burns contracture release, if the defect area is more than 1% but not more than 3% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $586.80 **Benefit:** 75% = $440.10
New 46115	Excised burn wound closure or closure of skin defect secondary to burns contracture release, if the defect area is more than 3% but not more than 10% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $643.65 **Benefit:** 75% = $482.75
New 46116	Excised burn wound closure or closure of skin defect secondary to burns contracture release, if the defect area is more than 10% but not more than 20% of total body surface and if the service:

	(a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $981.95 **Benefit:** 75% = $736.50
New 46117	Excised burn wound closure, if the defect area is 20% or more but less than 30% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,320.60 **Benefit:** 75% = $990.45
New 46118	Excised burn wound closure, if the defect area is 30% or more but less than 40% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,659.80 **Benefit:** 75% = $1244.85
New 46119	Excised burn wound closure, if the defect area is 40% or more but less than 50% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,998.45 **Benefit:** 75% = $1498.85
New 46120	Excised burn wound closure, if the defect area is 50% or more but less than 60% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves:

	(i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,336.50 **Benefit:** 75% = $1752.40
New 46121	Excised burn wound closure, if the defect area is 60% or more but less than 70% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,675.20 **Benefit:** 75% = $2006.40
New 46122	Excised burn wound closure, if the defect area is 70% or more but less than 80% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $3,048.05 **Benefit:** 75% = $2286.05
New 46123	Excised burn wound closure, if the defect area is 80% or more of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $3,413.65 **Benefit:** 75% = $2560.25
New 46124	Excised burn wound closure of whole of face, if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare, other than a service associated with a service to which item 46100 applies (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category)

	Fee: $1,884.50 **Benefit:** 75% = $1413.40
New 46125	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves less than 1% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $369.65 **Benefit:** 75% = $277.25 85% = $314.25
New 46126	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 1% or more but less than 3% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $586.80 **Benefit:** 75% = $440.10 85% = $498.80
New 46127	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 3% or more but less than 10% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $812.90 **Benefit:** 75% = $609.70
New 46128	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 10% or more but less than 30% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements), excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,490.25 **Benefit:** 75% = $1117.70
New 46129	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 30% or more of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements), excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,727.10 **Benefit:** 75% = $2045.35
New 46130	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves less than 1% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $369.65 **Benefit:** 75% = $277.25 85% = $314.25
New 46131	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 1% or more but less than 3% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $586.80 **Benefit:** 75% = $440.10
New 46132	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 3% or more but less than 10% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $643.65 **Benefit:** 75% = $482.75

New 46133	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 10% or more but less than 20% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $981.95 **Benefit:** 75% = $736.50
New 46134	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, if the defect area involves 20% or more but less than 30% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,173.15 **Benefit:** 75% = $1629.90
New 46135	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, if the defect area involves 30% or more of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $3,413.65 **Benefit:** 75% = $2560.25
New 46136	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, of whole of face, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare, other than a service associated with a service to which item 46100 applies (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,884.50 **Benefit:** 75% = $1413.40
New 46140	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is less than 1% of total body surface, including direct repair if performed (Anaes.) (Assist.) **Fee:** $281.95 **Benefit:** 75% = $211.50 85% = $239.70
New 46141	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 1% or more but less than 3% of total body surface (H) (Anaes.) (Assist.) **Fee:** $423.00 **Benefit:** 75% = $317.25
New 46142	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 3% or more but less than 10% of total body surface (H) (Anaes.) (Assist.) **Fee:** $507.45 **Benefit:** 75% = $380.60
New 46143	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 10% or more but less than 20% of total body surface (H) (Anaes.) (Assist.) **Fee:** $657.80 **Benefit:** 75% = $493.35
New 46150	Mandible or maxilla, procedure for advancement, retrusion or alteration of tilt, by osteotomy in standard planes, including fixation by any means (including application of distractors if used)—one service per patient on the same occasion (H) (Anaes.) (Assist.) (See para TN.8.107, CN.0.11, TN.8.269 of explanatory notes to this Category) **Fee:** $1,456.40 **Benefit:** 75% = $1092.30

New 46151	Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used)—conjoint surgery, principal specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) (See para TN.8.107, CN.0.11, TN.8.269 of explanatory notes to this Category) **Fee:** $1,588.00 **Benefit:** 75% = $1191.00
New 46152	Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used)—conjoint surgery, conjoint specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) (See para TN.8.107, CN.0.11, TN.8.269 of explanatory notes to this Category) **Fee:** $1,191.00 **Benefit:** 75% = $893.25
New 46153	Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used)—single surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) (See para TN.8.107, CN.0.11, TN.8.269 of explanatory notes to this Category) **Fee:** $1,984.90 **Benefit:** 75% = $1488.70
New 46154	Maxilla, procedure for reshaping arch of, by complex segmental osteotomies, including fixation by any means (including application of distractors if used), one service per patient on the same occasion (H) (Anaes.) (Assist.) (See para TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $1,662.20 **Benefit:** 75% = $1246.65
New 46155	Mandible, procedure for reshaping arch of, by complex segmental osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used), one service per patient on the same occasion (H) (Anaes.) (Assist.) (See para TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $1,662.20 **Benefit:** 75% = $1246.65
New 46156	Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used)—conjoint surgery, principal specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) (See para TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $1,897.60 **Benefit:** 75% = $1423.20
New 46157	Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used)—conjoint surgery, conjoint specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) (See para TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $1,423.20 **Benefit:** 75% = $1067.40
New 46158	Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies,

	including genioplasty (if performed) and fixation by any means (including application of distractors if used)—single surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) (See para TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $2,371.95 **Benefit:** 75% = $1779.00
New 46159	Midfacial osteotomies, Le Fort II or Le Fort III—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) (See para CN.0.11 of explanatory notes to this Category) **Fee:** $2,098.55 **Benefit:** 75% = $1573.95
New 46160	Midfacial osteotomies, Le Fort II or Le Fort III—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) (See para CN.0.11 of explanatory notes to this Category) **Fee:** $1,573.90 **Benefit:** 75% = $1180.45
New 46161	Midfacial osteotomies, Le Fort II or Le Fort III—single surgeon (H) (Anaes.) (Assist.) (See para CN.0.11 of explanatory notes to this Category) **Fee:** $2,623.15 **Benefit:** 75% = $1967.40
New 46170	Decompression of thoracic outlet, primary, for thoracic outlet syndrome, using any approach, including (if performed) division of scalene muscles, cervical rib and/or first rib resection (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $1,095.25 **Benefit:** 75% = $821.45
New 46171	Decompression of thoracic outlet, repeat (revision) procedure, for thoracic outlet syndrome, using any approach, including (if performed) division of scalene muscles, cervical rib and/or first rib resection (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $1,861.90 **Benefit:** 75% = $1396.45
New 46172	Removal or debulking of brachial plexus tumour, involving intraneural dissection, either supraclavicular or infraclavicular dissection (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,738.05 **Benefit:** 75% = $2053.55
New 46173	Removal or debulking of brachial plexus tumour, involving intraneural dissection, both supraclavicular and infraclavicular dissection (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $3,833.30 **Benefit:** 75% = $2875.00
New 46174	Exploration of the brachial plexus, either supraclavicular or infraclavicular, including any neurolyses performed and intraoperative neurophysiological recordings, but excluding reconstruction of elements (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,738.05 **Benefit:** 75% = $2053.55
New 46175	Exploration of the brachial plexus, both supraclavicular and infraclavicular, including any neurolyses performed and intraoperative neurophysiological recordings, but excluding reconstruction of elements (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $4,380.90 **Benefit:** 75% = $3285.70

	Exploration of the brachial plexus, posterior subscapular approach, all necessary elements of the operation including (but not limited to): (a) resection of the first rib and/or second rib; and (b) vertebral laminectomies or facetectomies, if performed; and (c) any neurolyses performed; and (d) intraoperative neurophysiological recordings; excluding the following: (e) reconstruction of elements of the plexus; (f) spinal instrumentation (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category)
New 46176	**Fee:** $1,095.25 **Benefit:** 75% = $821.45
	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, single surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category)
New 46177	**Fee:** $1,861.90 **Benefit:** 75% = $1396.45
	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category)
New 46178	**Fee:** $1,861.90 **Benefit:** 75% = $1396.45
	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category)
New 46179	**Fee:** $1,549.75 **Benefit:** 75% = $1162.35
	Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, single surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category)
New 46180	**Fee:** $2,738.05 **Benefit:** 75% = $2053.55
	Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category)
New 46181	**Fee:** $2,738.05 **Benefit:** 75% = $2053.55
	Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category)
New 46182	**Fee:** $2,283.55 **Benefit:** 75% = $1712.70
	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, single surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category)
New 46183	**Fee:** $3,285.65 **Benefit:** 75% = $2464.25
	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)
New 46184	(See para TN.8.270 of explanatory notes to this Category)

	Fee: $3,285.65 **Benefit:** 75% = $2464.25
New 46185	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,738.05 **Benefit:** 75% = $2053.55
	GENERAL
Amend Fee 45000	Single stage local muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals not in association with any of items 31356 to 31383 (Anaes.) **Fee:** $592.85 **Benefit:** 75% = $444.65 85% = $503.95
Amend Fee 45003	Single stage local myocutaneous flap repair to one defect, simple and small not in association with any of items 31356 to 31383 (Anaes.) **Fee:** $658.95 **Benefit:** 75% = $494.25 85% = $565.75 **Extended Medicare Safety Net Cap:** $527.20
Amend Fee 45006	Single stage large myocutaneous flap repair to one defect (pectoralis major, latissimus dorsi, or similar large muscle), other than a service associated with a service to which any of items 45524 to 45542 apply (H) (Anaes.) (Assist.) **Fee:** $1,136.50 **Benefit:** 75% = $852.40
Fee 45009	Single stage local muscle flap repair to 1 defect, simple and small, other than a service associated with a service to which item 30278, 30281 or 41722 applies (H) (Anaes.) (Assist.) **Fee:** $415.15 **Benefit:** 75% = $311.40
Amend Fee 45012	Single stage large muscle flap repair to one defect (pectoralis major, gastrocnemius, gracilis or similar large muscle), other than a service associated with a service to which any of items 45524 to 45542 apply (H) (Anaes.) (Assist.) **Fee:** $852.30 **Benefit:** 75% = $639.25
Fee 45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.) **Fee:** $329.40 **Benefit:** 75% = $247.05
Fee 45018	Dermis, dermofat or fascia graft (other than transfer of fat by injection): (a) if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items 51011 to 51171; and (b) other than a service associated with a service to which item 39615, 39715, 40106 or 40109 applies (Anaes.) (Assist.) **Fee:** $518.80 **Benefit:** 75% = $389.10 85% = $441.00
Fee 45019	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.) **Fee:** $434.50 **Benefit:** 75% = $325.90
Amend Fee 45021	Abrasive therapy for severely disfiguring scarring of face resulting from trauma, burns or acne, if sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes—limited to one claim per patient per episode (Anaes.) (See para TN.8.91 of explanatory notes to this Category) **Fee:** $194.25 **Benefit:** 75% = $145.70 85% = $165.15
Fee 45025	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) (See para TN.8.91 of explanatory notes to this Category) **Fee:** $194.25 **Benefit:** 75% = $145.70 85% = $165.15 **Extended Medicare Safety Net Cap:** $155.40
Fee 45026	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) (See para TN.8.91 of explanatory notes to this Category) **Fee:** $436.50 **Benefit:** 75% = $327.40 85% = $371.05 **Extended Medicare Safety Net Cap:** $349.20
Amend Fee 45027	Vascular anomaly, cauterisation of or injection into, if undertaken in the operating theatre of a hospital (Anaes.) (See para TN.8.263, TN.8.272 of explanatory notes to this Category) **Fee:** $131.85 **Benefit:** 75% = $98.90 85% = $112.10
Amend Fee 45030	Vascular anomaly, of skin, mucous membrane and/or subcutaneous tissue, small, excision and suture of (Anaes.) (See para TN.8.263 of explanatory notes to this Category) **Fee:** $148.65 **Benefit:** 75% = $111.50 85% = $126.40
Amend Fee 45033	Vascular anomaly, large or involving deeper tissue including facial muscle, excision and suture of (Anaes.) (Assist.) (See para TN.8.263 of explanatory notes to this Category) **Fee:** $269.35 **Benefit:** 75% = $202.05 85% = $228.95

Amend Fee 45035	Vascular anomaly, large, deep, and involving major neurovascular structures, excision of, including dissection of muscles, nerves or major vessels (H) (Anaes.) (Assist.) (See para TN.8.263 of explanatory notes to this Category) **Fee:** $768.90 **Benefit:** 75% = $576.70
Amend Fee 45036	Vascular anomaly, of neck, deep and involving major neurovascular structures, excision of, including dissection of cranial nerves and major vessels (H) (Anaes.) (Assist.) (See para TN.8.263 of explanatory notes to this Category) **Fee:** $1,235.50 **Benefit:** 75% = $926.65
Amend Fee 45045	Vascular anomaly on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) (See para TN.8.263 of explanatory notes to this Category) **Fee:** $337.80 **Benefit:** 75% = $253.35 85% = $287.15
Fee 45048	LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.) **Fee:** $848.35 **Benefit:** 75% = $636.30
Fee 45051	Contour reconstruction by open repair of contour defects, due to deformity, if: (a) contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery); and (b) insertion of a non-biological implant is required, other than one or more of the following: (i) insertion of a non-biological implant that is a component of another service specified in Group T8; (ii) injection of liquid or semisolid material; (iii) an oral and maxillofacial implant service to which item 52321 applies; (iv) a service to insert mesh; and (c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) **Fee:** $518.90 **Benefit:** 75% = $389.20
Amend Fee 45054	Limb or chest, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (H) (Anaes.) (Assist.) (See para TN.8.92 of explanatory notes to this Category) **Fee:** $357.10 **Benefit:** 75% = $267.85
Fee 45060	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.) **Fee:** $1,392.35 **Benefit:** 75% = $1044.30
Fee 45061	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.) **Fee:** $1,392.35 **Benefit:** 75% = $1044.30
Fee 45062	Developmental breast abnormality, 2 stage correction of, second stage, involving surgery on both breasts with a combination of exchange of one or more tissue expanders for one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if: (a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes. Applicable only once per occasion on which the service is provided (Anaes.) (Assist.) **Fee:** $1,007.55 **Benefit:** 75% = $755.70
	SKIN FLAP SURGERY
Amend Fee 45200	Single stage local flap, if indicated to repair one defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31383 (Anaes.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $311.45 **Benefit:** 75% = $233.60 85% = $264.75 **Extended Medicare Safety Net Cap:** $249.20
Amend Fee	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion (only in association with items 31000, 31001,

45201	31002, 31003, 31004, 31005, 31358, 31359, 31360, 31363, 31364, 31369, 31370, 31371, 31373, 31376, 31378, 31380 or 31383)-may be claimed only once per defect (Anaes.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $453.35 **Benefit:** 75% = $340.05 85% = $385.35
Fee 45202	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion in a patient, if the clinical relevance of the procedure is clearly annotated in the patient's record and either: (a) item 45201 applies and additional flap repair is required for the same defect; or (b) item 45201 does not apply and either: (i) the patient has severe pre-existing scarring, severe skin atrophy or sclerodermoid changes; or (ii) the repair is contiguous with a free margin (Anaes.) (See para TN.8.93, TN.8.126 of explanatory notes to this Category) **Fee:** $453.35 **Benefit:** 75% = $340.05 85% = $385.35
Amend Fee 45203	Single stage local flap, if indicated to repair one defect, complicated or large, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31383 (Anaes.) (Assist.) (See para TN.8.93, TN.8.207 of explanatory notes to this Category) **Fee:** $444.70 **Benefit:** 75% = $333.55 85% = $378.00 **Extended Medicare Safety Net Cap:** $355.80
Amend Fee 45206	Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap not in association with any of items 31356 to 31383 (Anaes.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $420.10 **Benefit:** 75% = $315.10 85% = $357.10 **Extended Medicare Safety Net Cap:** $336.10
Amend Fee 45207	H-flap or double advancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead not in association with any of items 31356 to 31383 (Anaes.) **Fee:** $420.10 **Benefit:** 75% = $315.10 85% = $357.10
Amend Fee 45209	Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), first stage of a multistage procedure (Anaes.) (Assist.) (See para TN.8.271, TN.8.272 of explanatory notes to this Category) **Fee:** $518.90 **Benefit:** 75% = $389.20 85% = $441.10
Amend Fee 45212	Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), subsequent stage of a multistage procedure (Anaes.) (Assist.) (See para TN.8.271 of explanatory notes to this Category) **Fee:** $257.45 **Benefit:** 75% = $193.10 85% = $218.85
Fee 45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.) **Fee:** $286.50 **Benefit:** 75% = $214.90 85% = $243.55
Fee 45224	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.)

	Fee: $128.75 **Benefit:** 75% = $96.60 85% = $109.45
Fee 45227	INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes.) (Assist.) **Fee:** $487.85 **Benefit:** 75% = $365.90 85% = $414.70
Fee 45230	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.) **Fee:** $243.95 **Benefit:** 75% = $183.00 85% = $207.40
Fee 45233	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.) **Fee:** $518.90 **Benefit:** 75% = $389.20 85% = $441.10
Amend Fee 45239	Direct, indirect, free or local flap, revision of, by incision and suture and/or liposuction, applicable once per flap, not being a service associated with a service to which item 45497 applies (Anaes.) **Fee:** $286.50 **Benefit:** 75% = $214.90 85% = $243.55
	FREE GRAFTS
Amend Fee 45451	Full thickness skin graft to one defect, with an average diameter of 5 mm or more (Anaes.) (Assist.) (See para TN.8.266 of explanatory notes to this Category) **Fee:** $518.90 **Benefit:** 75% = $389.20 85% = $441.10
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
Fee 45496	FLAP, free tissue transfer using microvascular techniques - *revision of*, by open operation (Anaes.) **Fee:** $455.70 **Benefit:** 75% = $341.80
Amend Fee 45497	Flap, free tissue transfer using microvascular techniques or any autologous breast reconstruction, revision of, by liposuction, other than a service associated with a service to which item 45239 applies (H) (Anaes.) **Fee:** $347.20 **Benefit:** 75% = $260.40
Amend Fee 45500	Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit; cannot be claimed by the same provider for both artery and vein (H) (Anaes.) (Assist.) **Fee:** $1,194.15 **Benefit:** 75% = $895.65
Amend Fee 45501	Microvascular anastomosis of artery or vein using microsurgical techniques, for replantation or revascularisation of limb or digit, if the limb or digit is devitalised and the repair is critical for restoration of blood supply, other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.) **Fee:** $1,943.70 **Benefit:** 75% = $1457.80
Amend Fee 45502	Microvascular anastomoses of artery and vein using microsurgical techniques, for replantation or revascularisation of limb or digit, if the limb or digit is devitalised and the repair is critical for restoration of blood supply, including anastomoses of all required vessels for that extremity or digit, unless a micro-arterial or micro-venous graft is being used, other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.) **Fee:** $2,915.50 **Benefit:** 75% = $2186.65

Amend Fee 45503	Micro-arterial or micro-venous graft using microsurgical techniques, if the graft is critical for restoration of blood supply, including harvest of graft and suturing of all related anastomoses (not to be claimed in the context of cardiac surgery) (H) (Anaes.) (Assist.) **Fee:** $2,223.70 **Benefit:** 75% = $1667.80
Amend Fee 45504	Microvascular anastomosis of artery, vein or veins, using microsurgical techniques, for free transfer of tissue, including setting in of free flap, other than: (a) a service for the purpose of breast reconstruction; or (b) a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.) **Fee:** $1,943.70 **Benefit:** 75% = $1457.80
Amend Fee 45505	Microvascular anastomoses of artery and vein or veins, using microsurgical techniques, for free transfer of tissue, including setting in of free flap, other than: (a) a service for the purpose of breast reconstruction; or (b) a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.) **Fee:** $2,943.50 **Benefit:** 75% = $2207.65
Fee 45512	SCAR, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $323.85 **Benefit:** 75% = $242.90 85% = $275.30
Amend Fee 45515	Scar, other than on face or neck, not more than 7 cm in length, revision of, if: (a) the service is: (i) undertaken in the operating theatre of a hospital; or (ii) performed by a specialist in the practice of the specialist's specialty; and (b) the service is not performed in conjunction with the insertion of breast implants for cosmetic purposes; and (c) the incision made for revision of the scar is not used as an approach for another procedure (including a non rebatable procedure); and (d) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $204.30 **Benefit:** 75% = $153.25 85% = $173.70
Amend Fee 45518	Scar, other than on face or neck, more than 7 cm in length, revision of, if: (a) the service is: (i) undertaken in the operating theatre of a hospital; or (ii) performed by a specialist in the practice of the specialist's specialty; and (b) the service is not performed in conjunction with the insertion of breast implants for cosmetic purposes; and (c) the incision made for revision of the scar is not used as an approach for another procedure (including a non rebatable procedure); and (d) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (Anaes.)

	(See para TN.8.95 of explanatory notes to this Category) **Fee:** $247.20 **Benefit:** 75% = $185.40 85% = $210.15
Amend Fee 45520	Reduction mammaplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast, other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $986.15 **Benefit:** 75% = $739.65
Amend Fee 45522	Reduction mammaplasty (unilateral) without surgical repositioning of the nipple: (a) excluding the treatment of gynaecomastia; and (b) not with insertion of any prosthesis; other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $691.90 **Benefit:** 75% = $518.95
Amend Fee 45523	Reduction mammaplasty (bilateral) with surgical repositioning of the nipple: (a) for patients with macromastia who are experiencing pain in the neck or shoulder region; and (b) not with insertion of any prosthesis; other than a service associated with a service to which item 31512, 31513 or 31514 applies (H) (Anaes.) (Assist.) **Fee:** $1,479.35 **Benefit:** 75% = $1109.55
Amend Fee 45524	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, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) (See para TN.8.96 of explanatory notes to this Category) **Fee:** $812.30 **Benefit:** 75% = $609.25
Amend Fee 45527	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) (See para TN.8.97 of explanatory notes to this Category) **Fee:** $1,173.25 **Benefit:** 75% = $879.95
Amend Fee 45528	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 or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $1,218.25 **Benefit:** 75% = $913.70
Amend Fee 45530	Post-mastectomy breast reconstruction, autologous (unilateral), using a large muscle or myocutaneous flap, isolated on its vascular pedicle, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45006 or 45012 applies (H) (Anaes.) (Assist.) (See para TN.8.97, TN.8.8 of explanatory notes to this Category) **Fee:** $1,204.10 **Benefit:** 75% = $903.10
Amend Fee 45534 S	Autologous fat grafting, unilateral service (harvesting, preparation and injection of adipocytes) if: (a) the autologous fat grafting is for one or more of the following purposes: (i) the correction of defects arising from treatment and prevention of breast cancer in patients with contour defects, greater than or equal to 20% volume asymmetry, post-treatment pain or poor prosthetic coverage; (ii) the preparation of post mastectomy thin or irradiated skin flaps in patients intending to have breast reconstruction; (iii) breast reconstruction in breast cancer patients; (iv) the correction of developmental disorders of the breast; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Up to a total of 4 services per side (for total treatment of a single breast), other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) **Fee:** $691.90 **Benefit:** 75% = $518.95
Amend Fee 45535 S	Autologous fat grafting, bilateral service (harvesting, preparation and injection of adipocytes) if: (a) the autologous fat grafting is for one or more of the following purposes: (i) the correction of defects arising from treatment and prevention of breast cancer in patients with contour defects, greater than or equal to 20% volume asymmetry, post-treatment pain or poor prosthetic coverage; (ii) the preparation of post mastectomy thin or irradiated skin flaps in patients intending to have breast reconstruction; (iii) breast reconstruction in breast cancer patients; (iv) the correction of developmental disorders of the breast; and

	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Up to a total of 4 services, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) **Fee:** $1,210.90 **Benefit:** 75% = $908.20
Amend Fee 45539	Breast reconstruction (unilateral), following mastectomy, using tissue expansion—insertion of tissue expansion unit and all attendances for subsequent expansion injections, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $1,579.35 **Benefit:** 75% = $1184.55
Amend Fee 45542	Breast reconstruction (unilateral), following mastectomy, using tissue expansion—removal of tissue expansion unit and insertion of permanent prosthesis, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $671.80 **Benefit:** 75% = $503.85
Fee 45545	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:** $681.85 **Benefit:** 75% = $511.40 85% = $588.65 **Extended Medicare Safety Net Cap:** $545.50
Fee 45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple (See para TN.8.100 of explanatory notes to this Category) **Fee:** $216.70 **Benefit:** 75% = $162.55 85% = $184.20
Fee 45548	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.) **Fee:** $303.15 **Benefit:** 75% = $227.40 85% = $257.70
Fee 45551	Breast prosthesis, removal of, with excision of at least half of the fibrous capsule, not with insertion of any prosthesis. The excised specimen must be sent for histopathology and the volume removed must be documented in the histopathology report (Anaes.) (Assist.) (See para TN.8.167 of explanatory notes to this Category) **Fee:** $485.95 **Benefit:** 75% = $364.50
Fee 45553	Breast prosthesis, removal of and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), if: (a) either: (i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or (ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)

	(See para TN.8.98, TN.8.262 of explanatory notes to this Category) **Fee:** $626.00 **Benefit:** 75% = $469.50
Fee 45554	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), including excision of at least half of the fibrous capsule or formation of a new pocket, or both, if: (a) either: (i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or (ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and (b) the excised specimen is sent for histopathology and the volume removed is documented in the histopathology report; and (c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) (See para TN.8.98, TN.8.262 of explanatory notes to this Category) **Fee:** $766.05 **Benefit:** 75% = $574.55
Amend Fee 45556	Breast ptosis, correction of (unilateral), in the context of breast cancer or developmental abnormality, if photographic evidence (including anterior, left lateral and right lateral views) 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, other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.99 of explanatory notes to this Category) **Fee:** $838.95 **Benefit:** 75% = $629.25
Amend Fee 45558	Correction of bilateral breast ptosis by mastopexy, if: (a) at least two-thirds of the breast tissue, including the nipple, lies inferior to the inframammary fold where the nipple is located at the most dependent, inferior part of the breast contour; and (b) photographic evidence (including anterior, left lateral and right lateral views), with a marker at the level of the inframammary fold, demonstrating the clinical need for this service, is documented in the patient notes Applicable only once per lifetime, other than a service associated with a service to which item 31512, 31513 or 31514 applies (H) (Anaes.) (Assist.) (See para TN.8.99 of explanatory notes to this Category) **Fee:** $1,258.40 **Benefit:** 75% = $943.80
Fee 45560	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes.) **Fee:** $518.80 **Benefit:** 75% = $389.10 85% = $441.00 **Extended Medicare Safety Net Cap:** $181.60

Amend Fee 45561	Microvascular anastomosis of artery and/or vein, if considered necessary to salvage a vascularly compromised pedicled or free flap, either during the primary procedure or at a subsequent return to theatre (H) (Anaes.) (Assist.) **Fee:** $1,943.70 **Benefit:** 75% = $1457.80
Amend Fee 45562	Free transfer of tissue (microvascular free flap) for non-breast defect involving raising of tissue on vascular pedicle, including direct repair of secondary cutaneous defect (if performed), other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (Anaes.) (Assist.) (See para TN.8.272 of explanatory notes to this Category) **Fee:** $1,204.10 **Benefit:** 75% = $903.10 85% = $1110.90
Amend Fee 45563	Neurovascular island flap for restoration of essential sensation in the digits or sole of the foot, or for genital reconstruction, including: (a) direct repair of secondary cutaneous defect (if performed); and (b) formal dissection of the neurovascular pedicle; other than a service performed on simple V-Y flaps or other standard flaps, such as rotation or keystone (Anaes.) (Assist.) (See para TN.8.272 of explanatory notes to this Category) **Fee:** $1,204.10 **Benefit:** 75% = $903.10 85% = $1110.90
Amend Fee 45564	Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) anastomoses of all required vessels; and (b) raising of tissue on a vascular pedicle; and (c) preparation of recipient vessels; and (d) transfer of tissue; and (e) insetting of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562 or 45567 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $2,788.80 **Benefit:** 75% = $2091.60
Amend Fee 45565	Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) anastomoses of all required vessels; and (b) raising of tissue on a vascular pedicle; and (c) preparation of recipient vessels; and (d) transfer of tissue; and (e) insetting of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562 or 45567 applies—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $2,091.70 **Benefit:** 75% = $1568.80

Amend Fee 45566	Insertion of a temporary prosthetic tissue expander which requires subsequent removal, including all attendances for subsequent expansion injections, other than a service for breast or post-mastectomy tissue expansion (H) (Anaes.) (Assist.) **Fee:** $1,173.25 **Benefit:** 75% = $879.95
Amend Fee 45568	Tissue expander, removal of, including complete excision of fibrous capsule if performed (H) (Anaes.) (Assist.) **Fee:** $485.95 **Benefit:** 75% = $364.50
Amend Fee 45572	Intra-operative tissue expansion using a prosthetic tissue expander, performed under general anaesthetic or intravenous sedation during an operation, if combined with a service to which another item in Group T8 applies (including expansion injections), not to be used for breast tissue expansion (Anaes.) **Fee:** $319.45 **Benefit:** 75% = $239.60 85% = $271.55
Fee 45575	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.) **Fee:** $788.80 **Benefit:** 75% = $591.60 85% = $695.60
Fee 45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.) **Fee:** $913.50 **Benefit:** 75% = $685.15
Amend Fee 45581	Facial nerve paralysis, excision of tissue for (Anaes.) **Fee:** $303.15 **Benefit:** 75% = $227.40 85% = $257.70
Fee 45584	Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), for treatment of post traumatic pseudolipoma, if photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.101 of explanatory notes to this Category) **Fee:** $691.90 **Benefit:** 75% = $518.95
Amend Fee 45585	Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), other than a service associated with a service to which item 31525 or 31526 applies, if: (a) the liposuction is for: (i) the treatment of Barraquer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or (ii) the reduction of a buffalo hump that is secondary to an endocrine disorder or pharmacological treatment of a medical condition; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (See para TN.8.101 of explanatory notes to this Category) **Fee:** $691.90 **Benefit:** 75% = $518.95
Fee 45587	Meloplasty for correction of facial asymmetry if: (a) the asymmetry is secondary to trauma (including previous surgery), a congenital condition or a medical condition (such as facial nerve palsy); and

	(b) the meloplasty is limited to one side of the face (Anaes.) (Assist.) (See para TN.8.102 of explanatory notes to this Category) **Fee:** $975.70 **Benefit:** 75% = $731.80
Fee 45588	Meloplasty (excluding browlifts and chinlift platysmaplasties), bilateral, if: (a) surgery is indicated to correct a functional impairment due to a congenital condition, disease (excluding post-acne scarring) or trauma (other than trauma resulting from previous elective cosmetic surgery); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) (See para TN.8.102 of explanatory notes to this Category) **Fee:** $1,463.65 **Benefit:** 75% = $1097.75
Fee 45589 S	Autologous fat grafting (harvesting, preparation and injection of adipocytes) if: (a) the autologous fat grafting is for either or both of the following purposes: (i) the correction of asymmetry arising from volume and contour defects in craniofacial disorders—up to a total of 4 services if each service is provided at least 3 months after the previous service; (ii) the treatment of burn scar or associated skin graft in the context of scar contracture, contour deformity or neuropathic pain, for patients who have undergone a minimum of 3 months of topical therapies, including silicone and pressure therapy, with an unsatisfactory or minimal level of improvement—up to a total of 4 services per region of the body (upper or lower limbs, trunk, neck or face) if each service provided per region of the body is provided at least 3 months after the previous such service; and (b) both: (i) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes; and (ii) for craniofacial disorders, evidence of diagnosis of the qualifying craniofacial disorder is documented in the patient notes (H) (Anaes.) **Fee:** $691.90 **Benefit:** 75% = $518.95
Amend Fee 45590	Orbital cavity, reconstruction of wall or floor, with or without bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 45594 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $529.30 **Benefit:** 75% = $397.00
Amend Fee 45596	Hemimaxillectomy (H) (Anaes.) (Assist.) (See para TN.8.264 of explanatory notes to this Category) **Fee:** $986.15 **Benefit:** 75% = $739.65

Amend Fee 45597	Total maxillectomy (bilateral) (H) (Anaes.) (Assist.) (See para TN.8.264 of explanatory notes to this Category) **Fee:** $1,320.15 **Benefit:** 75% = $990.15
Amend Fee 45599	Mandible, total resection of, other than a service associated with a service to which item 45608 applies (H) (Anaes.) (Assist.) **Fee:** $1,025.75 **Benefit:** 75% = $769.35
Fee 45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $766.05 **Benefit:** 75% = $574.55
Fee 45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $643.55 **Benefit:** 75% = $482.70
Amend Fee 45608	Mandible, segmental mandibular or maxilla reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (H) (Anaes.) (Assist.) **Fee:** $906.10 **Benefit:** 75% = $679.60
New 45609	Mandible, maxilla or skull base, reconstruction of, using bony free flap, all osteotomies, shaping, inset and fixation by any means, including all necessary 3 dimensional planning, if performed in conjunction with one or more services covered by items 46060 to 46068 (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $906.10 **Benefit:** 75% = $679.60
Amend Fee 45611	Mandible, condylectomy of (H) (Anaes.) (Assist.) **Fee:** $518.90 **Benefit:** 75% = $389.20
Amend Fee 45614	Eyelid, reconstruction of a defect (greater than one quarter of the length of the lid) involving all 3 layers of the eyelid, if unable to be closed by direct suture or wedge excision, including all flaps and grafts that may be required (Anaes.) (Assist.) (See para TN.8.272 of explanatory notes to this Category) **Fee:** $913.50 **Benefit:** 75% = $685.15 85% = $820.30 **Extended Medicare Safety Net Cap:** $730.80
Fee 45617	Upper eyelid, reduction of, if: (a) the reduction is for any of the following: (i) history of a demonstrated visual impairment; (ii) intertriginous inflammation of the eyelid; (iii) herniation of orbital fat in exophthalmos; (iv) facial nerve palsy; (v) post-traumatic scarring; (vi) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions mentioned in subparagraphs (i) to (v); and

	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.103 of explanatory notes to this Category) **Fee:** $257.45 **Benefit:** 75% = $193.10 85% = $218.85 **Extended Medicare Safety Net Cap:** $206.00
Fee 45620	Lower eyelid, reduction of, if: (a) the reduction is for: (i) herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring; or (ii) the restoration of symmetry of the contralateral lower eyelid in respect of one of these conditions; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.103 of explanatory notes to this Category) **Fee:** $357.10 **Benefit:** 75% = $267.85 85% = $303.55 **Extended Medicare Safety Net Cap:** $285.70
Fee 45623	Ptosis of upper eyelid (unilateral), correction of, by: (a) sutured elevation of the tarsal plate on the eyelid retractors (Muller's or levator muscle or levator aponeurosis); or (b) sutured suspension to the brow/frontalis muscle; Not applicable to a service for repair of mechanical ptosis to which item 45617 applies (Anaes.) (Assist.) **Fee:** $791.85 **Benefit:** 75% = $593.90 85% = $698.65 **Extended Medicare Safety Net Cap:** $633.50
Fee 45624	Ptosis of upper eyelid, correction of, by: (a) sutured elevation of the tarsal plate on the eyelid retractors (Muller's or levator muscle or levator aponeurosis); or (b) sutured suspension to the brow/frontalis muscle; if a previous ptosis surgery has been performed on that side (Anaes.) (Assist.) **Fee:** $1,026.70 **Benefit:** 75% = $770.05 85% = $933.50 **Extended Medicare Safety Net Cap:** $821.40
Fee 45625	PTOSIS of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital (Anaes.) **Fee:** $205.40 **Benefit:** 75% = $154.05
Fee 45626	Ectropion or entropion, not caused by trachoma, correction of (unilateral) (Anaes.) **Fee:** $357.10 **Benefit:** 75% = $267.85 85% = $303.55
Fee 45627 S	Ectropion or entropion, caused by trachoma, correction of (unilateral) (Anaes.)

	Fee: $357.10 **Benefit:** 75% = $267.85 85% = $303.55
Fee 45629	SYMBLEPHARON, grafting for (Anaes.) (Assist.) **Fee:** $518.90 **Benefit:** 75% = $389.20 85% = $441.10
Fee 45632	Rhinoplasty, partial, involving correction of one or both lateral cartilages, one or both alar cartilages or one or both lateral cartilages and 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.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $560.70 **Benefit:** 75% = $420.55 85% = $476.60 **Extended Medicare Safety Net Cap:** $448.60
Fee 45635	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.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $643.55 **Benefit:** 75% = $482.70 85% = $550.35 **Extended Medicare Safety Net Cap:** $514.85
Fee 45641	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: (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.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $1,167.50 **Benefit:** 75% = $875.65
Amend Fee 45644	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft, 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; other than a service associated with a service to which item 45718 applies (H) (Anaes.) (Assist.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $1,401.25 **Benefit:** 75% = $1050.95
Fee 45645	CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes.) **Fee:** $244.90 **Benefit:** 75% = $183.70
Fee 45646	CHOANAL ATRESIA - correction by open operation with bone removal (Anaes.) (Assist.) **Fee:** $986.15 **Benefit:** 75% = $739.65 85% = $892.95
Fee 45650	Rhinoplasty, revision of, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $161.80 **Benefit:** 75% = $121.35 85% = $137.55
Fee 45652	Rhinophyma of a moderate or severe degree, carbon dioxide laser or erbium laser excision - ablation of (Anaes.) **Fee:** $390.30 **Benefit:** 75% = $292.75 85% = $331.80 **Extended Medicare Safety Net Cap:** $312.25
Fee 45653	RHINOPHYMA, shaving of (Anaes.) **Fee:** $390.30 **Benefit:** 75% = $292.75 85% = $331.80
Fee 45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $550.05 **Benefit:** 75% = $412.55 85% = $467.55
Fee 45658 S	Correction of a congenital deformity of the ear if: (a) the congenital deformity is not related to a prominent ear; and (b) the deformity has been clinically diagnosed as a constricted ear, Stahl's ear, or a similar congenital deformity; and (c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes. (Anaes.) (Assist.)

	Fee: $570.95 **Benefit:** 75% = $428.25
Fee 45659	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 (c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Amend Fee 45660	External ear, complex total reconstruction of, using costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of the specialist's specialty (H) (Anaes.) (Assist.) **Fee:** $3,152.85 **Benefit:** 75% = $2364.65
Amend Fee 45661	External ear, complex total reconstruction of, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and skin graft to cover cartilage (second stage) - performed by a specialist in the practice of the specialist's specialty (H) (Anaes.) (Assist.) **Fee:** $1,401.25 **Benefit:** 75% = $1050.95
Amend Fee 45665	Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures, excluding eyelid wedge when performed in conjunction with a cosmetic eyelid procedure (Anaes.) **Fee:** $357.10 **Benefit:** 75% = $267.85 85% = $303.55
Fee 45668	VERMILIONECTOMY, by surgical excision (Anaes.) **Fee:** $357.10 **Benefit:** 75% = $267.85 85% = $303.55
Fee 45669	Vermilionectomy for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser excision - ablation (Anaes.) (See para TN.8.106 of explanatory notes to this Category) **Fee:** $357.10 **Benefit:** 75% = $267.85 85% = $303.55
Amend Fee 45671	Lip or eyelid reconstruction, single stage or first stage of a two-stage flap reconstruction of a defect involving all 3 layers of tissue, if the flap is switched from the opposing lip or eyelid respectively (Anaes.) (Assist.) (See para TN.8.272 of explanatory notes to this Category) **Fee:** $913.50 **Benefit:** 75% = $685.15 85% = $820.30
Amend Fee 45674	Lip or eyelid reconstruction, second stage of a two-stage flap reconstruction, division of the pedicle and inset of flap and closure of the donor (Anaes.) **Fee:** $265.70 **Benefit:** 75% = $199.30 85% = $225.85
Fee 45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $529.30 **Benefit:** 75% = $397.00
Fee 45676	MACROSTOMIA, operation for (Anaes.) (Assist.)

	Fee: $630.10 **Benefit:** 75% = $472.60
Amend Fee 45677	Cleft lip, unilateral—primary repair of nasolabial complex, one stage, without anterior palate repair (H) (Anaes.) (Assist.) **Fee:** $625.25 **Benefit:** 75% = $468.95
Amend Fee 45680	Cleft lip, unilateral—primary repair of nasolabial complex, one stage, with anterior palate repair (H) (Anaes.) (Assist.) **Fee:** $815.40 **Benefit:** 75% = $611.55
Amend Fee 45683	Cleft lip, bilateral—primary repair of nasolabial complex, one stage, without anterior palate repair (H) (Anaes.) (Assist.) **Fee:** $905.85 **Benefit:** 75% = $679.40
Amend Fee 45686	Cleft lip, bilateral—primary repair of nasolabial complex, one stage, with anterior palate repair (H) (Anaes.) (Assist.) **Fee:** $1,069.20 **Benefit:** 75% = $801.90
Fee 45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $286.70 **Benefit:** 75% = $215.05
Fee 45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00
Fee 45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $535.30 **Benefit:** 75% = $401.50
Fee 45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.) **Fee:** $502.45 **Benefit:** 75% = $376.85
Fee 45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $906.10 **Benefit:** 75% = $679.60
Fee 45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $329.40 **Benefit:** 75% = $247.05 85% = $280.00
Fee 45707	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $856.35 **Benefit:** 75% = $642.30
Fee 45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) **Fee:** $535.30 **Benefit:** 75% = $401.50
Fee 45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $609.60 **Benefit:** 75% = $457.20
Amend Fee	Oro-nasal fistula, repair of, including a local flap for closure (H) (Anaes.) (Assist.)

45714	**Fee:** $856.35 **Benefit:** 75% = $642.30
Fee 45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $856.35 **Benefit:** 75% = $642.30
Amend **Fee** 45761	Genioplasty, including transposition of nerves and vessels and bone grafts taken from the same site, if: (a) the deformity: (i) is secondary to congenital absence of tissue; or (ii) has arisen from trauma (other than from previous cosmetic surgery) or a diagnosed pathological process; and (b) the service is required for maintaining lip competency; and (c) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (H) (Anaes.) (Assist.) (See para TN.8.108 of explanatory notes to this Category) **Fee:** $819.95 **Benefit:** 75% = $615.00
Amend **Fee** 45767	Hypertelorism, correction of, using intracranial approach (H) (Anaes.) (Assist.) **Fee:** $2,750.85 **Benefit:** 75% = $2063.15
Amend **Fee** 45773	Syndromic orbital dystopia, such as Treacher Collins Syndrome, bilateral facial or periorbital reconstruction, with bone grafts from a distant site (H) (Anaes.) (Assist.) **Fee:** $1,920.35 **Benefit:** 75% = $1440.30
Fee 45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.) **Fee:** $1,920.35 **Benefit:** 75% = $1440.30
Fee 45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.) **Fee:** $1,411.90 **Benefit:** 75% = $1058.95
Amend **Fee** 45782	Fronto-orbital advancement (H) (Anaes.) (Assist.) **Fee:** $1,079.50 **Benefit:** 75% = $809.65
Amend **Fee** 45785	Cranial vault reconstruction for single suture synostosis (H) (Anaes.) (Assist.) **Fee:** $1,826.95 **Benefit:** 75% = $1370.25
Amend **Fee** 45788	Glenoid fossa, construction of, from bone and cartilage graft, and creation of condyle and ascending ramus of mandible, in hemifacial microsomia, not including harvesting of graft material (H) (Anaes.) (Assist.) **Fee:** $1,806.15 **Benefit:** 75% = $1354.65
Amend **Fee** 45791	Absent condyle and ascending ramus in craniofacial microsomia, construction of, not including harvesting of graft material (H) (Anaes.) (Assist.) **Fee:** $975.70 **Benefit:** 75% = $731.80

Amend Fee 45794	Osseo-integration procedure, first stage, implantation of fixture, following congenital absence, tumour or trauma, other than a service associated with a service to which item 41603 or 41604 applies (Anaes.) **Fee:** $551.90 **Benefit:** 75% = $413.95 85% = $469.15
Amend Fee 45797	Osseo-integration procedure, second stage, fixation of transcutaneous abutment, following congenital absence, tumour or trauma, other than a service associated with a service to which item 41603 or 41604 applies (Anaes.) **Fee:** $204.30 **Benefit:** 75% = $153.25 85% = $173.70
	ORAL AND MAXILLOFACIAL SURGERY
Amend Fee 45801	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral cavity, removal from mucosa or submucosal tissues, if the removal is by surgical excision and suture (Anaes.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $147.80 **Benefit:** 75% = $110.85 85% = $125.65
Fee 45807	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in this Subgroup applies, involving muscle, bone, or other deep tissue (Anaes.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $229.50
Fee 45809	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $406.90 **Benefit:** 75% = $305.20 85% = $345.90
Fee 45811	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $550.05 **Benefit:** 75% = $412.55 85% = $467.55
Fee 45813	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $643.55 **Benefit:** 75% = $482.70 85% = $550.35
Amend Fee 45815	Operation on: (a) mandible or maxilla (other than alveolar margins) for chronic osteomyelitis with radiological and laboratory evidence of osteomyelitis; or (b) mandible or maxilla for necrosis of the jaw from any cause including medication or radiation that requires debridement of the alveolar bone or beyond (Anaes.) (Assist.) **Fee:** $390.30 **Benefit:** 75% = $292.75 85% = $331.80

Amend Fee 45823	Arch bars or similar, one or more, that were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia, if the service is undertaken in the operating theatre of a hospital (H) (Anaes.) **Fee:** $119.25 **Benefit:** 75% = $89.45
Fee 45825	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $370.60 **Benefit:** 75% = $277.95 85% = $315.05
Fee 45827	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) **Fee:** $354.20 **Benefit:** 75% = $265.65 85% = $301.10
Fee 45829	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $270.20 **Benefit:** 75% = $202.65 85% = $229.70
Amend Fee 45831	Papillary hyperplasia of the palate, surgical reduction of—cannot be claimed more than once per occasion of service (Anaes.) (Assist.) **Fee:** $354.20 **Benefit:** 75% = $265.65 85% = $301.10
Fee 45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $642.35 **Benefit:** 75% = $481.80 85% = $549.15
Fee 45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $518.80 **Benefit:** 75% = $389.10 85% = $441.00
Amend Fee 45845	Osseo-integration procedure, intra-oral implantation of titanium or similar fixture to facilitate restoration of the dentition following: (a) resection of part of the maxilla or mandible for a benign or a malignant tumour; or (b) segmental loss from trauma or congenital absence of a segment of the maxilla or mandible (multiple adjacent teeth) Fixture must be placed at site of the missing segment following appropriate reconstructive procedures (Anaes.) **Fee:** $551.90 **Benefit:** 75% = $413.95 85% = $469.15
Amend Fee 45847	Osseo-integration procedure, fixation of transmucosal abutment to fixtures that are placed following: (a) resection of part of the maxilla or mandible for a benign or a malignant tumour; or (b) segmental loss from trauma or congenital absence of a segment of the maxilla or mandible (multiple adjacent teeth) Fixture must be placed at site of the missing segment following appropriate reconstructive procedures (Anaes.) **Fee:** $204.30 **Benefit:** 75% = $153.25 85% = $173.70
Amend Fee 45849	Maxillary sinus, allograft, bone graft or both, to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (Anaes.) (Assist.) **Fee:** $636.20 **Benefit:** 75% = $477.15 85% = $543.00
Amend Fee 45851	Temporomandibular joint, manipulation of, as an independent procedure performed in the operating theatre of a hospital, other than a service associated with a service to which any other item in this Group applies (H) (Anaes.)

T8. SURGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Fee: $156.65 **Benefit:** 75% = $117.50
Amend Fee 45855	Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (Anaes.) (Assist.) (See para TN.8.272 of explanatory notes to this Category) **Fee:** $318.20 **Benefit:** 75% = $238.65 85% = $270.50
Amend Fee 45857	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or lysis and lavage or biopsy (including repositioning of meniscus where indicated)—one or more such procedures of that joint, other than a service associated with any other arthroscopic or open procedure of the temporomandibular joint (Anaes.) (Assist.) (See para TN.8.272 of explanatory notes to this Category) **Fee:** $716.05 **Benefit:** 75% = $537.05 85% = $622.85
Fee 45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $318.20 **Benefit:** 75% = $238.65 85% = $270.50
Fee 45871	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,465.90 **Benefit:** 75% = $1099.45 85% = $1372.70
Amend Fee 45873	Temporomandibular joint, surgery of, involving procedures to which item 45871 applies and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,647.25 **Benefit:** 75% = $1235.45 85% = $1554.05
Fee 45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser. **Fee:** $47.10 **Benefit:** 75% = $35.35 85% = $40.05
Fee 45888	FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $452.95 **Benefit:** 75% = $339.75 85% = $385.05
Fee 45891	SINGLE-STAGE LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) **Fee:** $659.90 **Benefit:** 75% = $494.95 85% = $566.70
Amend Fee 45894	Grafting (mucosa or split skin), in the oral cavity of a mucosal defect (Anaes.) **Fee:** $224.20 **Benefit:** 75% = $168.15 85% = $190.60
Fee 45939	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) **Fee:** $489.65 **Benefit:** 75% = $367.25 85% = $416.25

T8. SURGICAL OPERATIONS	14. HAND SURGERY
	Group T8. Surgical Operations

	Subgroup 14. Hand Surgery
Fee 46300	Arthrodesis of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy —one joint (H) (Anaes.) (Assist.) **Fee:** $444.75 **Benefit:** 75% = $333.60
Fee 46303	Arthrodesis of carpometacarpal joint of hand, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy —one joint (H) (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50
Fee 46308	Volar plate or soft tissue interposition arthroplasty of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed): (a) realignment procedures; (b) tendon transfer —one joint (Anaes.) (Assist.) **Fee:** $576.60 **Benefit:** 75% = $432.45 85% = $490.15
Fee 46309	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer —one joint (H) (Anaes.) (Assist.) **Fee:** $576.60 **Benefit:** 75% = $432.45
Fee 46312	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy;

	(d) tendon transfer —2 joints of one hand (H) (Anaes.) (Assist.) **Fee:** $741.40 **Benefit:** 75% = $556.05
Fee 46315	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer —3 joints of one hand (H) (Anaes.) (Assist.) **Fee:** $988.55 **Benefit:** 75% = $741.45
Fee 46318	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer —4 joints of one hand (H) (Anaes.) (Assist.) **Fee:** $1,235.70 **Benefit:** 75% = $926.80
Fee 46321	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer; —5 joints of one hand (H) (Anaes.) (Assist.) **Fee:** $1,482.85 **Benefit:** 75% = $1112.15
Fee 46322	Revision of prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpal joint of hand, including any of the following (if performed): (a) bone grafting; (b) ligament reconstruction;

	(c) ligament realignment; (d) synovectomy; (e) tendon or ligament reconstruction; (f) tendon transfer; —one joint (H) (Anaes.) (Assist.) **Fee:** $865.00 **Benefit:** 75% = $648.75
Fee 46324	Trapezium replacement arthroplasty or prosthetic interpositional replacement of carpometacarpal joint of thumb, including either or both of the following (if performed): (a) ligament and tendon transfers; (b) rebalancing procedures (H) (Anaes.) (Assist.) **Fee:** $1,008.95 **Benefit:** 75% = $756.75
Fee 46325	Excisional arthroplasty of carpometacarpal joint of thumb, with excision of adjacent trapezoid, including either or both of the following (if performed): (a) ligament and tendon transfers; (b) realignment procedures (H) (Anaes.) (Assist.) **Fee:** $1,008.95 **Benefit:** 75% = $756.75
Fee 46330	Ligamentous or capsular repair or reconstruction of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) arthrotomy; (b) joint stabilisation; (c) synovectomy; —one joint (H) (Anaes.) (Assist.) **Fee:** $379.00 **Benefit:** 75% = $284.25
Fee 46333	Ligamentous or capsular repair or reconstruction of interphalangeal or metacarpophalangeal joint of hand with graft, using graft or implant, including any of the following (if performed): (a) arthrotomy; (b) harvest of graft; (c) joint stabilisation; (d) synovectomy;

	other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 apply—one joint (H) (Anaes.) (Assist.) **Fee:** $617.75 **Benefit:** 75% = $463.35
Fee 46335	Synovectomy of digital extensor tendons of hand, distal to wrist, for diagnosed inflammatory arthritis, including any of the following (if performed): (a) reconstruction of extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with a service to which item 30023, 39331 or 39330 applies—applicable only once per occasion on which the service is performed (Anaes.) (Assist.) (See para TN.8.184, TN.8.185 of explanatory notes to this Category) **Fee:** $510.60 **Benefit:** 75% = $382.95 85% = $434.05
Fee 46336	Synovectomy of interphalangeal, metacarpophalangeal or carpometacarpal joint of hand, including any of the following (if performed): (a) capsulectomy; (b) debridement; (c) ligament or tendon realignment (or both); other than a service combined with a service to which item 46495 applies—one joint (Anaes.) (Assist.) **Fee:** $288.35 **Benefit:** 75% = $216.30 85% = $245.10
Fee 46339	Synovectomy of digital flexor tendons at wrist level, for diagnosed inflammatory arthritis, including either or both of the following (if performed): (a) tenolysis; (b) release of median nerve and carpal tunnel; other than a service associated with a service to which item 30023, 39331 or 39330 applies—applicable only once per occasion on which the service is performed (H) (Anaes.) (Assist.) **Fee:** $510.60 **Benefit:** 75% = $382.95
Fee 46340	Synovectomy of wrist flexor or extensor tendons of hand or wrist, for diagnosed inflammatory tenosynovitis, including any of the following (if performed): (a) reconstruction of flexor or extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty;

	other than a service associated with a service to which item 30023, 39331 or 39330 applies—one or more compartments (H) (Anaes.) (Assist.) (See para TN.8.184, TN.8.185 of explanatory notes to this Category) **Fee:** $434.05 **Benefit:** 75% = $325.55
Fee 46341	Synovectomy of wrist flexor or extensor tendons of hand or wrist, for non-inflammatory tenosynovitis or post traumatic synovitis, including any of the following (if performed): (a) reconstruction of flexor or extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with a service to which item 30023, 39331 or 39330 applies—one or more compartments (H) (Anaes.) (Assist.) (See para TN.8.185 of explanatory notes to this Category) **Fee:** $278.35 **Benefit:** 75% = $208.80
Fee 46342	Synovectomy of distal radioulnar or carpometacarpal joint of hand—one or more joints (H) (Anaes.) (Assist.) **Fee:** $510.60 **Benefit:** 75% = $382.95
Fee 46345	Resection arthroplasty of distal radioulnar joint of hand, partial or complete, including any of the following (if performed): (a) ligament or tendon reconstruction; (b) joint stabilisation; (c) synovectomy (H) (Anaes.) (Assist.) **Fee:** $617.75 **Benefit:** 75% = $463.35
Fee 46348	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with a service to which item 30023 or 46363 applies—one ray (H) (Anaes.) (Assist.) **Fee:** $267.70 **Benefit:** 75% = $200.80
Fee 46351	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules;

	(b) tenolysis; (c) tenoplasty; other than a service associated with a service to which item 30023 or 46363 applies—2 rays of one hand (H) (Anaes.) (Assist.) **Fee:** $399.55 **Benefit:** 75% = $299.70
Fee 46354	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with a service to which item 30023 or 46363 applies—3 rays of one hand (H) (Anaes.) (Assist.) **Fee:** $535.40 **Benefit:** 75% = $401.55
Fee 46357	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with a service to which item 30023 or 46363 applies—4 rays of one hand (H) (Anaes.) (Assist.) **Fee:** $667.25 **Benefit:** 75% = $500.45
Fee 46360	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with a service to which item 30023 or 46363 applies—5 rays of one hand (H) (Anaes.) (Assist.) **Fee:** $803.20 **Benefit:** 75% = $602.40
Fee 46363	Trigger finger release, for stenosing tenosynoviti, including either or both of the following (if performed): (a) synovectomy; (b) synovial biopsy;

	—one ray (Anaes.) (Assist.) **Fee:** $230.60 **Benefit:** 75% = $172.95 85% = $196.05
Fee 46364	Digital sympathectomy of hand, using microsurgical techniques, other than a service associated with a service to which item 30023 or 46363 applies—one digit or palmer arch (or both) or radial or ulnar artery (or both) (Anaes.) (Assist.) **Fee:** $510.60 **Benefit:** 75% = $382.95 85% = $434.05
Fee 46365	Excision of rheumatoid nodules of hand —one lesion (Anaes.) (Assist.) **Fee:** $288.35 **Benefit:** 75% = $216.30 85% = $245.10
Fee 46367	De Quervain's release, including any of the following (if performed): (a) synovectomy of extensor pollicis brevis; (b) synovectomy of abductor pollicis longus tendons; (c) retinaculum reconstruction; other than a service associated with a service to which item 46339 applies (Anaes.) (Assist.) **Fee:** $435.45 **Benefit:** 75% = $326.60 85% = $370.15
Fee 46370	Percutaneous fasciotomy for Dupuytren’s contracture, by needle or chemical method, including either or both of the following (if performed): (a) immediate or delayed manipulation; (b) local or regional nerve block; —one ray (Anaes.) (Assist.) **Fee:** $140.10 **Benefit:** 75% = $105.10 85% = $119.10
Fee 46372	Fasciectomy for Dupuytren’s contracture, including dissection of nerves (if performed)—one ray (H) (Anaes.) (Assist.) **Fee:** $468.65 **Benefit:** 75% = $351.50
Fee 46375	Fasciectomy for Dupuytren’s contracture, including dissection of nerves (if performed)—2 rays (H) (Anaes.) (Assist.) **Fee:** $556.00 **Benefit:** 75% = $417.00
Fee 46378	Fasciectomy for Dupuytren’s contracture, including dissection of nerves (if performed)—3 rays (H) (Anaes.) (Assist.) **Fee:** $741.40 **Benefit:** 75% = $556.05
Fee 46379	Fasciectomy for Dupuytren’s contracture, including dissection of nerves (if performed)—4 rays (H) (Anaes.) (Assist.) **Fee:** $934.05 **Benefit:** 75% = $700.55
Fee 46380	Fasciectomy for Dupuytren’s contracture, including dissection of nerves (if performed)—5 rays (H) (Anaes.) (Assist.) **Fee:** $1,176.85 **Benefit:** 75% = $882.65

Fee 46381	Release of interphalangeal joint of hand, by open procedure, when performed in conjunction with an operation for Dupuytren's contracture—one joint (H) (Anaes.) (Assist.) **Fee:** $329.45 **Benefit:** 75% = $247.10
Fee 46384	Z-plasty or similar local flap procedure, when performed in conjunction with an operation for Dupuytren's contracture, including raising, transfer in-setting and suturing of both components (flaps)—one Z-plasty or local flap procedure (H) (Anaes.) (Assist.) **Fee:** $329.45 **Benefit:** 75% = $247.10
Fee 46387	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies—one ray (H) (Anaes.) (Assist.) **Fee:** $679.70 **Benefit:** 75% = $509.80
Fee 46390	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies—2 rays (H) (Anaes.) (Assist.) **Fee:** $906.35 **Benefit:** 75% = $679.80
Fee 46393	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies—3 rays (H) (Anaes.) (Assist.) **Fee:** $1,050.30 **Benefit:** 75% = $787.75
Fee 46394	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies—4 rays (H) (Anaes.) (Assist.) **Fee:** $1,308.85 **Benefit:** 75% = $981.65

Fee 46395	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies—5 rays (H) (Anaes.) (Assist.) **Fee:** $1,631.05 **Benefit:** 75% = $1223.30
Fee 46399	Osteotomy of phalanx or metacarpal of hand, with internal fixation—one bone (H) (Anaes.) (Assist.) **Fee:** $567.10 **Benefit:** 75% = $425.35
Fee 46401	Operative treatment of non-union of phalanx or metacarpal of hand, including internal fixation (if performed) (Anaes.) (Assist.) **Fee:** $455.15 **Benefit:** 75% = $341.40 85% = $386.90
Fee 46408	Reconstruction of tendon of hand or wrist, by tendon graft, including either or both of the following (if performed): (a) harvest of graft; (b) tenolysis; other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.) **Fee:** $757.85 **Benefit:** 75% = $568.40
Fee 46411	Reconstruction of complete flexor tendon pulley of hand or wrist, with graft, including harvest of graft (if performed)—one pulley (H) (Anaes.) (Assist.) **Fee:** $444.80 **Benefit:** 75% = $333.60
Fee 46414	Insertion of artificial tendon prosthesis in preparation for grafting of tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.) (Assist.) **Fee:** $576.50 **Benefit:** 75% = $432.40 85% = $490.05
Fee 46417	Transfer of tendon of hand or wrist, for restoration of hand or digit motion, including harvest of donor motor unit (if performed)—one transfer (H) (Anaes.) (Assist.) **Fee:** $535.40 **Benefit:** 75% = $401.55
Fee 46420	Primary repair of extensor tendon of hand or wrist—one tendon (Anaes.) (Assist.) **Fee:** $224.05 **Benefit:** 75% = $168.05 85% = $190.45
Fee 46423	Delayed repair of extensor tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.) (Assist.) **Fee:** $358.35 **Benefit:** 75% = $268.80 85% = $304.60
Fee 46426	Primary repair of flexor tendon of hand or wrist, proximal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure—one tendon (H) (Anaes.) (Assist.)

	Fee: $370.65 **Benefit:** 75% = $278.00
Fee 46432	Primary repair of flexor tendon of hand or wrist, distal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure—one tendon (H) (Anaes.) (Assist.) **Fee:** $617.95 **Benefit:** 75% = $463.50
Fee 46434	Delayed repair of flexor tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.) (Assist.) **Fee:** $532.40 **Benefit:** 75% = $399.30 85% = $452.55
Fee 46438	Closed pin fixation of mallet finger (Anaes.) **Fee:** $148.30 **Benefit:** 75% = $111.25 85% = $126.10
Fee 46441	Open reduction of mallet finger, including any of the following (if performed): (a) joint release; (b) pin fixation; (c) tenolysis (Anaes.) (Assist.) **Fee:** $358.35 **Benefit:** 75% = $268.80 85% = $304.60
Fee 46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.) **Fee:** $307.65 **Benefit:** 75% = $230.75
Fee 46444	Reconstruction of Boutonniere or swan neck deformity of hand, including either or both of the following (if performed): (a) tendon graft harvest; (b) tendon transfer —one joint (H) (Anaes.) (Assist.) **Fee:** $535.40 **Benefit:** 75% = $401.55
Fee 46450	Tenolysis of extensor tendon of hand or wrist, following tendon injury or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item 30023 applies —one ray (H) (Anaes.) **Fee:** $247.20 **Benefit:** 75% = $185.40
Fee 46453	Tenolysis of flexor tendon of hand or wrist, following tendon injury, repair or graft, other than a service: (a) for acute, traumatic injury; or

	(b) associated with a service to which item 30023 applies (H) (Anaes.) (Assist.) **Fee:** $411.90 **Benefit:** 75% = $308.95
Fee 46456	Percutaneous tenotomy of digit of hand (Anaes.) **Fee:** $107.10 **Benefit:** 75% = $80.35 85% = $91.05
Fee 46464	Amputation of a supernumerary complete digit of hand (H) (Anaes.) (Assist.) **Fee:** $247.20 **Benefit:** 75% = $185.40
Fee 46465	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps —one ray (H) (Anaes.) (Assist.) **Fee:** $247.20 **Benefit:** 75% = $185.40
Fee 46468	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps —2 rays (H) (Anaes.) (Assist.) **Fee:** $432.45 **Benefit:** 75% = $324.35
Fee 46471	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps —3 rays (H) (Anaes.) (Assist.) **Fee:** $617.75 **Benefit:** 75% = $463.35
Fee 46474	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps —4 rays (H) (Anaes.) (Assist.) **Fee:** $803.20 **Benefit:** 75% = $602.40

Fee 46477	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps —5 rays (H) (Anaes.) (Assist.) **Fee:** $988.55 **Benefit:** 75% = $741.45
Fee 46480	Amputation of ray of hand, proximal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) recontouring; (c) resection of bone; (d) skin cover with local flaps —one ray (H) (Anaes.) (Assist.) **Fee:** $411.90 **Benefit:** 75% = $308.95
Fee 46483	Revision of amputation stump of hand to provide adequate cover, including any of the following (if performed): (a) bone shortening; (b) excision of nail bed remnants; (c) excision of neuroma (H) (Anaes.) (Assist.) **Fee:** $329.45 **Benefit:** 75% = $247.10
Fee 46486	Accurate reconstruction of acute nail bed laceration using magnification (H) (Anaes.) **Fee:** $247.20 **Benefit:** 75% = $185.40
Fee 46489	Secondary reconstruction of nail bed deformity using magnification, including removal of nail (if performed), other than a service associated with a service to which item 46513 or 45451 applies (H) (Anaes.) (Assist.) (See para TN.8.188 of explanatory notes to this Category) **Fee:** $288.35 **Benefit:** 75% = $216.30
Fee 46492	Surgical correction of contracture of joint of hand, flexor or extensor tendon, involving tissues deeper than skin and subcutaneous tissue—one joint (H) (Anaes.) (Assist.) **Fee:** $395.45 **Benefit:** 75% = $296.60
Fee 46493	Resection of boss of metacarpal base of hand, including either or both of the following (if performed): (a) excision of ganglion;

	(b) synovectomy (Anaes.) (Assist.) **Fee:** $360.95 **Benefit:** 75% = $270.75 85% = $306.85
Fee 46495	Complete excision of one or more ganglia or mucous cysts of interphalangeal, metacarpophalangeal or carpometacarpal joint of hand, including any of the following (if performed): (a) arthrotomy; (b) osteophyte resections (c) synovectomy other than a service associated with a service to which item 30107 or 46336 applies—one joint (H) (Anaes.) (Assist.) **Fee:** $222.55 **Benefit:** 75% = $166.95
Fee 46498	Excision of ganglion of flexor tendon sheath of hand, including any of the following (if performed): (a) flexor tenosynovectomy; (b) sheath excision; (c) skin closure by any method other than a service associated with a service to which item 30107 or 46363 applies (Anaes.) (Assist.) **Fee:** $240.85 **Benefit:** 75% = $180.65 85% = $204.75
Fee 46500	Excision of ganglion of dorsal wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) **Fee:** $288.35 **Benefit:** 75% = $216.30 85% = $245.10
Fee 46501	Excision of ganglion of volar wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy; other than a service associated with a service to which item 30107 or 46325 applies (Anaes.) (Assist.) **Fee:** $360.55 **Benefit:** 75% = $270.45 85% = $306.50
Fee 46502	Excision of recurrent ganglion of dorsal wrist joint of hand, including any of the following (if performed):

	(a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy (Anaes.) (Assist.) **Fee:** $432.50 **Benefit:** 75% = $324.40 85% = $367.65
Fee 46503	Excision of recurrent ganglion of volar wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy; other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) **Fee:** $414.40 **Benefit:** 75% = $310.80 85% = $352.25
Fee 46504	Neurovascular island flap, heterodigital, for pulp re-innervation and soft tissue cover (Anaes.) (Assist.) (See para TN.8.187 of explanatory notes to this Category) **Fee:** $1,210.80 **Benefit:** 75% = $908.10 85% = $1117.60
Fee 46507	Transposition or transfer of digit or ray on vascular pedicle of hand, including any of the following (if performed): (a) nerve transfer; (b) skin closure, by any means; (c) rebalancing procedures (H) (Anaes.) (Assist.) **Fee:** $1,642.80 **Benefit:** 75% = $1232.10
Fee 46510	Surgical reduction of enlarged elements resulting from macrodactyly, including any of the following (if performed): (a) nerve transfer; (b) skin closure, by any means; (c) rebalancing procedures —one digit (H) (Anaes.) (Assist.) **Fee:** $384.40 **Benefit:** 75% = $288.30
Fee 46513	Removal of nail of finger or thumb—one nail (Anaes.) **Fee:** $61.85 **Benefit:** 75% = $46.40 85% = $52.60

Fee 46519	Drainage of midpalmar, thenar or hypothenar spaces or dorsum of hand, excluding aftercare (Anaes.) (Assist.) **Fee:** $154.65 **Benefit:** 75% = $116.00 85% = $131.50
Fee 46522	Open operation and drainage of infection for flexor tendon sheath of finger or thumb, including either or both of the following (if performed): (a) synovectomy; (b) tenolysis; other than a service associated with a service to which item 30023 applies—one digit (H) (Anaes.) (Assist.) **Fee:** $461.30 **Benefit:** 75% = $346.00
Fee 46525	Incision for pulp space infection of hand: (a) other than a service: (i) to which another item in this Group applies; or (ii) associated with a service to which item 30023 applies; and (b) excluding aftercare (H) (Anaes.) **Fee:** $61.85 **Benefit:** 75% = $46.40
Fee 46528	Wedge resection for ingrowing nail of finger or thumb: (a) including each of the following: (i) excision and partial ablation of germinal matrix; (ii) removal of segment of nail; (iii) removal of ungual fold; and (b) including phenolisation (if performed) (Anaes.) **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80
Fee 46531	Partial resection of ingrowing nail of finger or thumb, including phenolisation (Anaes.) **Fee:** $93.25 **Benefit:** 75% = $69.95 85% = $79.30
Fee 46534	Complete ablation of nail germinal matrix (H) (Anaes.) (Assist.) **Fee:** $257.90 **Benefit:** 75% = $193.45

	Group T8. Surgical Operations

	Subgroup 15. Orthopaedic
New 47766	Naso-orbital-ethmoidal complex, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one or more sites (H) (Anaes.) (Assist.) **Fee:** $658.20 **Benefit:** 75% = $493.65
Fee 49783	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —3 joints (H) (Anaes.) (Assist.) **Fee:** $830.45 **Benefit:** 75% = $622.85
	TREATMENT OF DISLOCATIONS
Amend Fee 47000	Mandible, treatment of dislocation of, by closed reduction, requiring general anaesthesia or intravenous sedation, if performed in the operating theatre of a hospital (H) (Anaes.) **Fee:** $77.45 **Benefit:** 75% = $58.10
Fee 47003	Treatment of dislocation of clavicle, by closed reduction (Anaes.) **Fee:** $92.90 **Benefit:** 75% = $69.70 85% = $79.00
Fee 47007	Repair of acromioclavicular or sternoclavicular joint dislocation (acute or chronic), by open, mini-open or arthroscopic technique, including either or both of the following (if performed): (a) ligament augmentation; (b) tendon transfers (Anaes.) (Assist.) **Fee:** $386.70 **Benefit:** 75% = $290.05 85% = $328.70
Fee 47009	Treatment of dislocation of shoulder, requiring general anaesthesia, other than a service to which item 47012 applies (Anaes.) **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80
Fee 47012	Treatment of dislocation of shoulder, requiring general anaesthesia, by open reduction (H) (Anaes.) (Assist.) **Fee:** $371.10 **Benefit:** 75% = $278.35
Fee 47015	Treatment of dislocation of shoulder, not requiring general anaesthesia **Fee:** $92.90 **Benefit:** 75% = $69.70 85% = $79.00
Fee 47018	Treatment of dislocation of elbow, by closed reduction (Anaes.)

	Fee: $216.40 **Benefit:** 75% = $162.30 85% = $183.95
Fee 47021	Treatment of dislocation of elbow, by open reduction (H) (Anaes.) (Assist.) **Fee:** $288.70 **Benefit:** 75% = $216.55
Fee 47024	Treatment of dislocation of distal or proximal radioulnar joint, by closed reduction, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating fracture or dislocation in the same region (Anaes.) **Fee:** $216.40 **Benefit:** 75% = $162.30 85% = $183.95
Fee 47027	Treatment of dislocation of distal or proximal radioulnar joint, by open reduction, including either or both of the following (if performed): (a) styloid fracture; (b) triangular fibrocartilage complex repair; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating fracture or dislocation in the same region (Anaes.) (Assist.) **Fee:** $711.60 **Benefit:** 75% = $533.70 85% = $618.40
Fee 47030	Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by closed reduction (Anaes.) **Fee:** $216.40 **Benefit:** 75% = $162.30 85% = $183.95
Fee 47033	Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by open reduction, including ligament repair (if performed) (Anaes.) (Assist.) **Fee:** $711.60 **Benefit:** 75% = $533.70 85% = $618.40
Fee 47042	Treatment of dislocation of interphalangeal or metacarpophalangeal joint, by closed reduction (Anaes.) **Fee:** $123.60 **Benefit:** 75% = $92.70 85% = $105.10
Fee 47045	Treatment of dislocation of interphalangeal or metacarpophalangeal joint, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) ligament repair; (d) volar plate repair (Anaes.) (Assist.) **Fee:** $461.60 **Benefit:** 75% = $346.20 85% = $392.40
Fee 47047	Treatment of dislocation of prosthetic hip, by closed reduction (Anaes.) (Assist.) **Fee:** $355.70 **Benefit:** 75% = $266.80 85% = $302.35
Fee 47049	Treatment of dislocation of prosthetic hip, by open reduction (Anaes.) (Assist.) **Fee:** $474.20 **Benefit:** 75% = $355.65 85% = $403.10

Fee 47052	Treatment of dislocation of native hip, by closed reduction (Anaes.) (Assist.) **Fee:** $462.45 **Benefit:** 75% = $346.85 85% = $393.10
Fee 47053	Treatment of dislocation of native hip, by open reduction, with internal fixation (if performed) (Anaes.) (Assist.) **Fee:** $616.40 **Benefit:** 75% = $462.30 85% = $523.95
Fee 47054	Treatment of dislocation of knee, by closed reduction, including application of external fixator (if performed) (Anaes.) (Assist.) **Fee:** $355.70 **Benefit:** 75% = $266.80 85% = $302.35
Fee 47057	Treatment of dislocation of patella, by closed reduction (Anaes.) **Fee:** $139.15 **Benefit:** 75% = $104.40 85% = $118.30
Fee 47060	Treatment of dislocation of patella, by open reduction (Anaes.) (Assist.) **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80
Fee 47063	Treatment of dislocation of ankle or tarsus, by closed reduction (Anaes.) (Assist.) **Fee:** $278.35 **Benefit:** 75% = $208.80 85% = $236.60
Fee 47066	Treatment of dislocation of ankle or tarsus, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint (H) (Anaes.) (Assist.) **Fee:** $371.10 **Benefit:** 75% = $278.35
Fee 47069	Treatment of dislocation of toe, by closed reduction—one toe (Anaes.) **Fee:** $77.45 **Benefit:** 75% = $58.10 85% = $65.85
	TREATMENT OF FRACTURES
Fee 47301	Treatment of fracture of middle or proximal phalanx, by closed reduction, requiring anaesthesia—one bone (Anaes.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $95.05 **Benefit:** 75% = $71.30 85% = $80.80
Fee 47304	Treatment of fracture of metacarpal, by closed reduction, requiring anaesthesia—one bone (H) (Anaes.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $108.30 **Benefit:** 75% = $81.25
Fee 47307	Treatment of fracture of phalanx or metacarpal, by closed reduction, including percutaneous K-wire fixation (if performed)—one bone (H) (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $219.05 **Benefit:** 75% = $164.30

	Treatment of fracture of phalanx or metacarpal, by open reduction, with internal fixation (H) (Anaes.) (Assist.)
Fee 47310	(See para TN.8.124 of explanatory notes to this Category) **Fee:** $361.45 **Benefit:** 75% = $271.10
	Treatment of intra-articular fracture of phalanx or metacarpal, by closed reduction, including: (a) percutaneous K-wire fixation; and (b) external or dynamic fixation (if performed) (H) (Anaes.) (Assist.)
Fee 47313	(See para TN.8.124 of explanatory notes to this Category) **Fee:** $350.50 **Benefit:** 75% = $262.90
	Treatment of intra-articular fracture of phalanx or metacarpal, by open reduction with fixation, other than a service provided on the same occasion as a service to which item 47319 applies (H) (Anaes.) (Assist.)
Fee 47316	(See para TN.8.124 of explanatory notes to this Category) **Fee:** $695.45 **Benefit:** 75% = $521.60
	Treatment of intra-articular fracture of proximal end of middle phalanx, by open reduction, with fixation, other than a service provided on the same occasion as a service to which item 47316 applies (H) (Anaes.) (Assist.)
Fee 47319	(See para TN.8.124 of explanatory notes to this Category) **Fee:** $711.90 **Benefit:** 75% = $533.95
	Treatment of fracture of carpus (excluding scaphoid), by cast immobilisation, other than a service associated with a service to which item 47351 applies (Anaes.)
Fee 47348	**Fee:** $102.95 **Benefit:** 75% = $77.25 85% = $87.55
	Treatment of fracture of carpus (excluding scaphoid), by open reduction, with internal fixation (Anaes.) (Assist.)
Fee 47351	**Fee:** $257.90 **Benefit:** 75% = $193.45 85% = $219.25
	Treatment of fracture of carpal scaphoid, by cast immobilisation, other than a service associated with a service to which item 47357 applies (Anaes.)
Fee 47354	**Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80
	Treatment of fracture of carpal scaphoid, by open reduction, with internal or percutaneous fixation (Anaes.) (Assist.)
Fee 47357	**Fee:** $412.40 **Benefit:** 75% = $309.30 85% = $350.55
	Treatment of fracture of distal end of radius or ulna (or both), by cast immobilisation, other than a service associated with a service to which item 47362, 47364, 47367, 47370 or 47373 applies
Fee 47361	(See para TN.8.124 of explanatory notes to this Category) **Fee:** $144.35 **Benefit:** 75% = $108.30 85% = $122.70
Fee 47362	Treatment of fracture of distal end of radius or ulna (or both), by closed reduction, requiring general or major regional anaesthesia, but excluding local infiltration, other than a service associated with a

	service to which item 47361, 47364, 47367, 47370 or 47373 applies (Anaes.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $216.40 **Benefit:** 75% = $162.30 85% = $183.95
Fee 47364	Treatment of fracture of distal end of radius or ulna (not involving joint surface), by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $306.65 **Benefit:** 75% = $230.00
Fee 47367	Treatment of fracture of distal end of radius, by closed reduction with percutaneous fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $244.90 **Benefit:** 75% = $183.70
Fee 47370	Treatment of intra-articular fracture of distal end of radius, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $444.65 **Benefit:** 75% = $333.50
Fee 47373	Treatment of intra-articular fracture of distal end of ulna, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $317.65 **Benefit:** 75% = $238.25
Fee 47381	Treatment of fracture of shaft of radius or ulna, by closed reduction (H) (Anaes.) **Fee:** $278.35 **Benefit:** 75% = $208.80
Fee 47384	Treatment of fracture of shaft of radius or ulna, by open reduction with internal fixation (H) (Anaes.) (Assist.) **Fee:** $371.10 **Benefit:** 75% = $278.35
Fee 47385	Treatment of: (a) fracture of shaft of radius or ulna; and (b) dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury); by closed reduction (H) (Anaes.) (Assist.) **Fee:** $319.50 **Benefit:** 75% = $239.65
Fee 47386	Treatment of: (a) fracture of shaft of radius or ulna; and (b) dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury); by open reduction, with internal fixation, including reduction of dislocation (if performed) (H) (Anaes.) (Assist.)

	Fee: $515.50 **Benefit:** 75% = $386.65
Fee 47387	Treatment of fracture of distal or shaft of radius or ulna (or both), by cast immobilisation, other than a service to which item 47390 or 47393 applies (Anaes.) (Assist.) **Fee:** $298.95 **Benefit:** 75% = $224.25 85% = $254.15
Fee 47390	Treatment of fracture of shafts of radius and ulna, by closed reduction (H) (Anaes.) **Fee:** $448.55 **Benefit:** 75% = $336.45
Fee 47393	Treatment of fracture of shafts of radius and ulna, by open reduction, with internal fixation (H) (Anaes.) (Assist.) **Fee:** $598.00 **Benefit:** 75% = $448.50
Fee 47396	Treatment of fracture of olecranon, by closed reduction (Anaes.) **Fee:** $206.10 **Benefit:** 75% = $154.60 85% = $175.20
Fee 47399	Treatment of fracture of olecranon, by open reduction (H) (Anaes.) (Assist.) **Fee:** $412.40 **Benefit:** 75% = $309.30
Fee 47402	Treatment of fracture of olecranon, with excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.) **Fee:** $309.20 **Benefit:** 75% = $231.90 85% = $262.85
Fee 47405	Treatment of fracture of head or neck of radius, by closed reduction (Anaes.) **Fee:** $206.10 **Benefit:** 75% = $154.60 85% = $175.20
Fee 47408	Treatment of fracture of head or neck of radius, by open reduction, including internal fixation and excision (if performed) (H) (Anaes.) (Assist.) **Fee:** $412.40 **Benefit:** 75% = $309.30
Fee 47411	Treatment of fracture of tuberosity of humerus, other than a service to which item 47417 applies (Anaes.) **Fee:** $123.60 **Benefit:** 75% = $92.70 85% = $105.10
Fee 47414	Treatment of fracture of tuberosity of humerus, by open reduction (Anaes.) **Fee:** $247.50 **Benefit:** 75% = $185.65 85% = $210.40
Fee 47417	Treatment of fracture of tuberosity of humerus and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $288.70 **Benefit:** 75% = $216.55 85% = $245.40
Fee 47420	Treatment of fracture of tuberosity of humerus and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.) **Fee:** $567.10 **Benefit:** 75% = $425.35
Fee 47423	Humerus, proximal, treatment of fracture of, other than a service to which item 47426, 47429 or 47432 applies (Anaes.) **Fee:** $237.10 **Benefit:** 75% = $177.85 85% = $201.55
Fee 47426	Humerus, proximal, treatment of fracture of, by closed reduction (H) (Anaes.)

	Fee: $355.70 **Benefit:** 75% = $266.80
Fee 47429	Humerus, proximal, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) **Fee:** $474.20 **Benefit:** 75% = $355.65
Fee 47432	Humerus, proximal, treatment of intra-articular fracture of, by open reduction (H) (Anaes.) (Assist.) **Fee:** $592.80 **Benefit:** 75% = $444.60
Fee 47435	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $453.70 **Benefit:** 75% = $340.30 85% = $385.65
Fee 47438	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.) **Fee:** $721.90 **Benefit:** 75% = $541.45
Fee 47441	Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.) **Fee:** $902.20 **Benefit:** 75% = $676.65
Fee 47444	Humerus, shaft of, treatment of fracture of, other than a service to which item 47447 or 47450 applies (Anaes.) **Fee:** $247.50 **Benefit:** 75% = $185.65 85% = $210.40
Fee 47447	Humerus, shaft of, treatment of fracture of, by closed reduction (H) (Anaes.) **Fee:** $371.10 **Benefit:** 75% = $278.35
Fee 47450	Humerus, shaft of, treatment of fracture of, by internal or external fixation (H) (Anaes.) (Assist.) **Fee:** $495.00 **Benefit:** 75% = $371.25
Fee 47451	Humerus, shaft of, treatment of fracture of, by intramedullary fixation (H) (Anaes.) (Assist.) **Fee:** $596.65 **Benefit:** 75% = $447.50
Fee 47453	Humerus, distal, (supracondylar or condylar), treatment of fracture of, other than a service to which item 47456 or 47459 applies (Anaes.) (Assist.) **Fee:** $288.70 **Benefit:** 75% = $216.55 85% = $245.40
Fee 47456	Humerus, distal (supracondylar or condylar), treatment of fracture of, by closed reduction (H) (Anaes.) (Assist.) **Fee:** $433.20 **Benefit:** 75% = $324.90
Fee 47459	Humerus, distal (supracondylar or condylar), treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) **Fee:** $577.50 **Benefit:** 75% = $433.15
Fee 47462	Clavicle, treatment of fracture of, other than a service to which item 47465 applies (Anaes.) **Fee:** $123.60 **Benefit:** 75% = $92.70 85% = $105.10
Fee 47465	Clavicle, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $567.10 **Benefit:** 75% = $425.35 85% = $482.05

Fee 47466	Sternum, treatment of fracture of, other than a service to which item 47467 applies (Anaes.) **Fee:** $123.60 **Benefit:** 75% = $92.70 85% = $105.10
Fee 47467	Sternum, treatment of fracture of, by open reduction (H) (Anaes.) **Fee:** $247.50 **Benefit:** 75% = $185.65
Fee 47468	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $474.20 **Benefit:** 75% = $355.65 85% = $403.10
Fee 47471	RIBS (one or more), treatment of fracture of - each attendance **Fee:** $47.10 **Benefit:** 75% = $35.35 85% = $40.05
Fee 47474	PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum **Fee:** $206.10 **Benefit:** 75% = $154.60 85% = $175.20
Fee 47477	PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum **Fee:** $257.90 **Benefit:** 75% = $193.45 85% = $219.25
Fee 47480	PELVIC RING, treatment of fracture of, requiring traction (H) (Anaes.) (Assist.) **Fee:** $515.50 **Benefit:** 75% = $386.65
Fee 47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (H) (Anaes.) (Assist.) **Fee:** $618.65 **Benefit:** 75% = $464.00
Fee 47486	Treatment of fracture of anterior pelvic ring or sacroiliac joint disruption (or both), by open reduction, with internal fixation (H) (Anaes.) (Assist.) **Fee:** $1,031.10 **Benefit:** 75% = $773.35
Fee 47489	Treatment of fracture of posterior pelvic ring or sacroiliac joint disruption (or both), by open reduction, with internal fixation (H) (Anaes.) (Assist.) **Fee:** $1,546.65 **Benefit:** 75% = $1160.00
Fee 47495	Treatment of fracture of acetabulum and associated dislocation of hip, including the application and management of traction (if performed), excluding aftercare (Anaes.) (Assist.) **Fee:** $515.50 **Benefit:** 75% = $386.65 85% = $438.20
Fee 47498	Treatment of isolated posterior wall fracture of acetabulum and associated dislocation of hip, by open reduction, with internal fixation, including the application and management of traction (if performed) (H) (Anaes.) (Assist.) **Fee:** $773.25 **Benefit:** 75% = $579.95
Fee 47501	Treatment of anterior or posterior column fracture of acetabulum, by open reduction, with internal fixation, including any of the following (if performed): (a) capsular stabilisation; (b) capsulotomy; (c) osteotomy

	(H) (Anaes.) (Assist.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $1,031.10 **Benefit:** 75% = $773.35
Fee 47511	Treatment of combined column T-Type, transverse, anterior column or posterior hemitransverse fractures of acetabulum, by open reduction, with internal fixation, performed through single or dual approach (including fixation of the posterior wall fracture), including any of the following (if performed): (a) capsular stabilisation; (b) capsulotomy; (c) osteotomy (H) (Anaes.) (Assist.) **Fee:** $1,546.65 **Benefit:** 75% = $1160.00
Fee 47514	Treatment of posterior wall fracture of acetabulum and associated femoral head fracture, by open reduction, with internal fixation (H) (Anaes.) (Assist.) **Fee:** $902.20 **Benefit:** 75% = $676.65
Fee 47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) **Fee:** $474.20 **Benefit:** 75% = $355.65 85% = $403.10
Fee 47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (H) (Anaes.) (Assist.) **Fee:** $948.65 **Benefit:** 75% = $711.50
Fee 47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.) **Fee:** $825.00 **Benefit:** 75% = $618.75
Fee 47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.) **Fee:** $1,051.70 **Benefit:** 75% = $788.80
Fee 47534	Femur, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of one or more osteochondral fragments (H) (Anaes.) (Assist.) **Fee:** $1,185.75 **Benefit:** 75% = $889.35
Fee 47537	Femur, condylar region of, treatment of fracture of, requiring internal fixation of one or more osteochondral fragments, other than a service associated with a service to which item 47534 applies (Anaes.) (Assist.) **Fee:** $474.20 **Benefit:** 75% = $355.65 85% = $403.10
Fee 47540	Hip spica or shoulder spica, application of, as an independent procedure (Anaes.) **Fee:** $237.10 **Benefit:** 75% = $177.85 85% = $201.55
Fee 47543	Tibia, plateau of, treatment of medial or lateral fracture of, other than a service to which item 47546 or 47549 applies (Anaes.) **Fee:** $247.50 **Benefit:** 75% = $185.65 85% = $210.40

Fee 47546	Tibia, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.) **Fee:** $371.10 **Benefit:** 75% = $278.35 85% = $315.45
Fee 47549	Treatment of medial or lateral fracture of plateau of tibia, by open reduction, with internal fixation, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) meniscal repair (H) (Anaes.) (Assist.) **Fee:** $589.50 **Benefit:** 75% = $442.15
Fee 47552	Tibia, plateau of, treatment of both medial and lateral fractures of, other than a service to which item 47555 or 47558 applies (Anaes.) (Assist.) **Fee:** $412.40 **Benefit:** 75% = $309.30 85% = $350.55
Fee 47555	Tibia, plateau of, treatment of both medial and lateral fractures of, by closed reduction (H) (Anaes.) **Fee:** $618.65 **Benefit:** 75% = $464.00
Fee 47558	Treatment of medial and lateral fractures of tibia, by open reduction, with internal fixation, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) meniscal repair (H) (Anaes.) (Assist.) **Fee:** $1,093.00 **Benefit:** 75% = $819.75
Fee 47559	Treatment of medial or lateral (or both) fracture of plateau of tibia, with application of a bridging external fixator to the plateau (Anaes.) (Assist.) **Fee:** $837.05 **Benefit:** 75% = $627.80 85% = $743.85
Fee 47561	Treatment of fracture of shaft of tibia, by cast immobilisation, other than a service to which item 47570 or 47573 applies (Anaes.) **Fee:** $298.95 **Benefit:** 75% = $224.25 85% = $254.15
Fee 47565	Tibia, shaft of, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.) **Fee:** $780.20 **Benefit:** 75% = $585.15
Fee 47566	Tibia, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.) **Fee:** $994.55 **Benefit:** 75% = $745.95
Fee 47568	Closed reduction of proximal tibia, distal tibia or shaft of tibia, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $448.55 **Benefit:** 75% = $336.45 85% = $381.30

Fee 47570	Tibia, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $598.00 **Benefit:** 75% = $448.50 85% = $508.30
Fee 47573	Treatment of proximal or distal intra-articular fracture of shaft of tibia, by open reduction, with or without treatment of fibular fracture, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) capsule repair; (d) removal of intervening soft tissue; (e) removal of loose fragments; (f) washout of joint; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating a medial malleolus fracture of the distal tibia (H) (Anaes.) (Assist.) **Fee:** $747.55 **Benefit:** 75% = $560.70
Fee 47579	Treatment of fracture of patella, other than a service to which item 47582 or 47585 applies (Anaes.) **Fee:** $175.30 **Benefit:** 75% = $131.50 85% = $149.05
Fee 47582	Treatment of fracture of patella, with internal fixation, including bone grafting (if performed), other than a service associated with a service to which item 47579 or 47585 applies (H) (Anaes.) (Assist.) **Fee:** $464.15 **Benefit:** 75% = $348.15
Fee 47585	Treatment of proximal or distal fracture of patella, by open reduction, with internal fixation, including any of the following (if performed): (a) arthrotomy; (b) excision of patellar pole, with reattachment of tendon; (c) removal of loose fragments; (d) repair of quadriceps or patellar tendon (or both); (e) stabilisation of patello-femoral joint (H) (Anaes.) (Assist.) **Fee:** $479.80 **Benefit:** 75% = $359.85
Fee 47588	Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of one or more ligaments (H) (Anaes.) (Assist.) **Fee:** $1,443.35 **Benefit:** 75% = $1082.55

Fee 47591	Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of one or more ligaments (H) (Anaes.) (Assist.) **Fee:** $1,753.05 **Benefit:** 75% = $1314.80
Fee 47593	Repair or reconstruction (or both) of acute traumatic chondral injury to the distal femoral and proximal tibial articular surfaces of the knee, using chondral or osteochondral implants or transfers (H) (Anaes.) (Assist.) **Fee:** $873.95 **Benefit:** 75% = $655.50
Fee 47595	Treatment of fracture of ankle joint, hindfoot, midfoot, metatarsals or toes, by non-surgical management—one leg (Anaes.) **Fee:** $176.45 **Benefit:** 75% = $132.35 85% = $150.00
Fee 47597	Treatment of fracture of ankle joint, by closed reduction (Anaes.) (Assist.) **Fee:** $355.70 **Benefit:** 75% = $266.80 85% = $302.35
Fee 47600	Treatment of fracture of ankle joint: (a) by internal fixation of the malleolus, fibula or diastasis; and (b) including any of the following (if performed): (i) arthrotomy; (ii) capsule repair; (iii) removal of loose fragments or intervening soft tissue; (iv) washout of joint (H) (Anaes.) (Assist.) **Fee:** $618.65 **Benefit:** 75% = $464.00
Fee 47603	Treatment of fracture of ankle joint: (a) by internal fixation of 2 or more of the malleolus, fibula, diastasis and medial tissue interposition; and (b) including any of the following (if performed): (i) arthrotomy; (ii) capsule repair; (iii) removal of loose fragments or intervening soft tissue; (iv) washout of joint (H) (Anaes.) (Assist.) **Fee:** $780.20 **Benefit:** 75% = $585.15

Fee 47612	Treatment of intra-articular fracture of hindfoot, by closed reduction, with or without dislocation—one foot (Anaes.) (Assist.) **Fee:** $448.55 **Benefit:** 75% = $336.45 85% = $381.30
Fee 47615	Treatment of fracture of hindfoot, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint —one foot (Anaes.) (Assist.) **Fee:** $515.50 **Benefit:** 75% = $386.65 85% = $438.20
Fee 47618	Treatment of intra-articular fracture of hindfoot, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint —one foot (H) (Anaes.) (Assist.) **Fee:** $644.45 **Benefit:** 75% = $483.35
Fee 47621	Treatment of intra-articular fracture of midfoot, by closed reduction, with or without dislocation—one foot (Anaes.) (Assist.) **Fee:** $448.55 **Benefit:** 75% = $336.45 85% = $381.30
Fee 47624	Treatment of fracture of tarso-metatarsal, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule or ligament repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint —one joint (H) (Anaes.) (Assist.) **Fee:** $618.65 **Benefit:** 75% = $464.00
Fee 47630	Treatment of fracture of cuneiform, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy;

	(b) capsule or ligament repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint —one bone (Anaes.) (Assist.) **Fee:** $371.10 **Benefit:** 75% = $278.35 85% = $315.45
Fee 47637	Treatment of fractures of metatarsal, by closed reduction—one or more metatarsals of one foot (Anaes.) (Assist.) **Fee:** $210.10 **Benefit:** 75% = $157.60 85% = $178.60
Fee 47639	Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed)—one metatarsal (Anaes.) (Assist.) **Fee:** $247.50 **Benefit:** 75% = $185.65 85% = $210.40
Fee 47648	Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed)—2 metatarsals of one foot (H) (Anaes.) (Assist.) **Fee:** $329.70 **Benefit:** 75% = $247.30
Fee 47657	Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed)—3 or more metatarsals of one foot (H) (Anaes.) (Assist.) **Fee:** $515.50 **Benefit:** 75% = $386.65
Fee 47663	Treatment of fracture of phalanx of toe, by closed reduction—one toe (Anaes.) **Fee:** $154.65 **Benefit:** 75% = $116.00 85% = $131.50
Fee 47666	Treatment of fracture or dislocation of phalanx of great toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint — one great toe (Anaes.) **Fee:** $257.90 **Benefit:** 75% = $193.45 85% = $219.25
Fee 47672	Treatment of fracture or dislocation of phalanx of toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments;

	(d) removal of intervening soft tissue; (e) washout of joint —one toe (other than great toe) of one foot (Anaes.) **Fee:** $123.60 **Benefit:** 75% = $92.70 85% = $105.10
Fee 47678	Treatment of fracture or dislocation of phalanx of toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint —2 or more toes (other than great toe) of one foot (Anaes.) **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80
Fee 47735	Nasal bones, treatment of fracture of, other than a service to which item 47738 or 47741 applies—each attendance **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
Fee 47738	Nasal bones, treatment of fracture of, by reduction (Anaes.) **Fee:** $257.90 **Benefit:** 75% = $193.45 85% = $219.25
Fee 47741	Nasal bones, treatment of fracture of, by open reduction involving osteotomies (H) (Anaes.) (Assist.) **Fee:** $526.10 **Benefit:** 75% = $394.60
Amend Fee 47753	Maxilla or mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.) **Fee:** $445.30 **Benefit:** 75% = $334.00
Amend Fee 47762	Zygomatic arch, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach, other than a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $261.55 **Benefit:** 75% = $196.20 85% = $222.35
Amend Fee 47765	Zygomaticomaxillary complex/malar, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one or more sites (H) (Anaes.) (Assist.) **Fee:** $492.10 **Benefit:** 75% = $369.10
Amend Fee 47786	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving one or more plates (H) (Anaes.) (Assist.) **Fee:** $787.15 **Benefit:** 75% = $590.40
Amend Fee 47789	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving one or more plates (H) (Anaes.) (Assist.)

	Fee: $787.15 **Benefit:** 75% = $590.40
	GENERAL OPERATIONS
Fee 47790 S	Tendon, large, lengthening of, as an independent procedure (Anaes.) (Assist.) **Fee:** $309.20 **Benefit:** 75% = $231.90 85% = $262.85
Fee 47791 S	Tenosynovectomy, not being a service associated with a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $288.70 **Benefit:** 75% = $216.55 85% = $245.40
Fee 47792 S	Joint stabilisation procedure of acromio-clavicular joint or scapulo-thoracic joint, including any of the following (if performed): (a) arthrotomy; (b) osteotomy, with or without fixation; (c) local tendon transfer; (d) local tendon lengthening or release; (e) ligament repair; (f) joint debridement; not being a service associated with a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $515.50 **Benefit:** 75% = $386.65 85% = $438.20
Fee 47900	Injection into, or aspiration of, unicameral bone cyst (Anaes.) (See para TN.8.169 of explanatory notes to this Category) **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80
Fee 47903	Epicondylitis, open operation for (Anaes.) **Fee:** $257.90 **Benefit:** 75% = $193.45 85% = $219.25
Fee 47904	Digital nail of toe, removal of, not being a service to which item 47906 applies (Anaes.) **Fee:** $61.85 **Benefit:** 75% = $46.40 85% = $52.60
Fee 47906	Digital nail of toe, removal of, in the operating theatre of a hospital (H) (Anaes.) **Fee:** $123.60 **Benefit:** 75% = $92.70
Fee 47915	Wedge resection for ingrowing nail of toe: (a) including each of the following: (i) removal of segment of nail; (ii) removal of ungual fold; (iii) excision and partial ablation of germinal matrix and portion of nail bed; and (b) including phenolisation (if performed)

	(Anaes.) (Assist.) **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80
Fee 47916	Partial resection for ingrowing nail of toe, including phenolisation (Anaes.) **Fee:** $93.25 **Benefit:** 75% = $69.95 85% = $79.30
Fee 47918	Complete ablation of nail germinal matrix: (a) including each of the following: (i) removal of segment of nail; (ii) removal of ungual fold; (iii) excision and ablation of germinal matrix and portion of nail bed; and (b) including phenolisation (if performed) (Anaes.) (Assist.) **Fee:** $257.90 **Benefit:** 75% = $193.45 85% = $219.25
Fee 47921	Orthopaedic pin or wire, insertion of, as an independent procedure (Anaes.) **Fee:** $123.60 **Benefit:** 75% = $92.70 85% = $105.10
Fee 47924	Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes), with incision, other than a service associated with a service to which item 47927 or 47929 applies—one bone (Anaes.) (See para TN.8.179 of explanatory notes to this Category) **Fee:** $41.25 **Benefit:** 75% = $30.95 85% = $35.10
Fee 47927	Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes)—one bone (H) (Anaes.) (See para TN.8.179 of explanatory notes to this Category) **Fee:** $154.65 **Benefit:** 75% = $116.00
Fee 47929	Removal of fixation elements (including plate, rod or nail and associated wires, pins, screws or external fixation), other than a service associated with a service to which item 47924 or 47927 applies—one bone (H) (Anaes.) (Assist.) (See para TN.8.179 of explanatory notes to this Category) **Fee:** $412.40 **Benefit:** 75% = $309.30
Fee 47953	Repair of distal biceps brachii tendon, by any method, performed as an independent procedure (Anaes.) (Assist.) **Fee:** $474.20 **Benefit:** 75% = $355.65 85% = $403.10
Fee 47954	Repair of traumatic tear or rupture of tendon, other than a service associated with: (a) a service to which item 39330 applies; or (b) a service to which another item in this Schedule applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region (Anaes.) (Assist.) (See para TN.8.180 of explanatory notes to this Category)

	Fee: $412.40 **Benefit:** 75% = $309.30 85% = $350.55
Fee 47955	Repair of gluteal or rectus femoris tendon, by open or arthroscopic means, when performed as an independent procedure, including either or both of the following (if performed): (a) bursectomy; (b) preparation of greater trochanter; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.) **Fee:** $713.70 **Benefit:** 75% = $535.30
Fee 47956	Repair of proximal hamstring tendon, performed as an independent procedure, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.) **Fee:** $1,070.50 **Benefit:** 75% = $802.90
Fee 47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) **Fee:** $144.35 **Benefit:** 75% = $108.30 85% = $122.70
Fee 47964	Iliopsoas tenotomy, by open or arthroscopic means, when performed as an independent procedure, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.) **Fee:** $237.10 **Benefit:** 75% = $177.85
Fee 47967	Restoration of shoulder or elbow function by major muscle tendon transfer, including associated dissection of neurovascular pedicle, excluding micro-anastomosis and biceps tenodesis—one transfer (H) (Anaes.) (Assist.) **Fee:** $474.20 **Benefit:** 75% = $355.65
Fee 47975	Forearm or calf, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.) (Assist.) **Fee:** $404.35 **Benefit:** 75% = $303.30
Fee 47978	Forearm or calf, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.) **Fee:** $245.60 **Benefit:** 75% = $184.20
Fee 47981	Forearm, calf or interosseous muscle space of hand, decompression fasciotomy of, other than a service to which another item in this Group applies (Anaes.) **Fee:** $164.90 **Benefit:** 75% = $123.70 85% = $140.20
Fee 47982	Forage (Drill decompression), of neck or head of femur, or both (H) (Anaes.) (Assist.) **Fee:** $399.70 **Benefit:** 75% = $299.80
Fee 47983	Stabilisation of slipped capital femoral epiphysis, by internal fixation (H) (Anaes.) (Assist.) **Fee:** $948.65 **Benefit:** 75% = $711.50

Fee 47984	Open subcapital realignment of slipped capital femoral epiphysis, other than a service associated with a service to which item 48427 applies (H) (Anaes.) (Assist.) **Fee:** $948.65 **Benefit:** 75% = $711.50
	BONE GRAFTS
Fee 48245	Harvesting and insertion of bone graft (autograft) via separate incisions and at separate surgical fields (H) (Anaes.) (Assist.) (See para TN.8.177 of explanatory notes to this Category) **Fee:** $342.55 **Benefit:** 75% = $256.95
Fee 48248	Harvesting and insertion of bone graft (autograft) via separate incisions, including internal fixation of the graft or fusion fixation (or both) (H) (Anaes.) (Assist.) (See para TN.8.177 of explanatory notes to this Category) **Fee:** $530.50 **Benefit:** 75% = $397.90
Fee 48251	Harvesting and insertion of osteochondral graft (autograft) via separate incisions at the same joint or joint complex (H) (Anaes.) (Assist.) (See para TN.8.177 of explanatory notes to this Category) **Fee:** $436.55 **Benefit:** 75% = $327.45
Fee 48254	Harvesting and insertion of pedicled bone flap (autograft), including internal fixation of the bone flap (if performed), other than a service associated with a service to which item 45562, 45504 or 45505 applies (H) (Anaes.) (Assist.) (See para TN.8.177 of explanatory notes to this Category) **Fee:** $1,000.20 **Benefit:** 75% = $750.15
Fee 48257	Preparation and insertion of metallic, cortical or other graft substitute (allograft), where substitute is structural cortico-cancellous bone or structural bone (or both), including internal fixation (if performed) (H) (Anaes.) (Assist.) (See para TN.8.177, TN.8.178 of explanatory notes to this Category) **Fee:** $436.55 **Benefit:** 75% = $327.45
	OSTEOTOMY AND OSTEECTOMY
Fee 48400	Osteotomy of phalanx or metatarsal of foot, for correction of deformity, excision of accessory bone or sesamoid bone, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; —one bone (H) (Anaes.) (Assist.) (See para TN.8.168, TN.8.200, TN.8.223, TN.8.196 of explanatory notes to this Category) **Fee:** $360.95 **Benefit:** 75% = $270.75
Fee 48403	Osteotomy of phalanx or metatarsal of first toe of foot, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone;

	(b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; —one bone (H) (Anaes.) (Assist.) (See para TN.8.168, TN.8.200, TN.8.223, TN.8.196 of explanatory notes to this Category) **Fee:** $567.10 **Benefit:** 75% = $425.35
Fee 48406	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; —one bone (H) (Anaes.) (Assist.) (See para TN.8.168, TN.8.200, TN.8.196 of explanatory notes to this Category) **Fee:** $360.95 **Benefit:** 75% = $270.75
Fee 48409	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; —one bone (H) (Anaes.) (Assist.) (See para TN.8.168, TN.8.200, TN.8.196 of explanatory notes to this Category) **Fee:** $567.10 **Benefit:** 75% = $425.35
Fee 48412	Osteotomy of humerus, without internal fixation (H) (Anaes.) (Assist.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $690.70 **Benefit:** 75% = $518.05
Fee 48415	Osteotomy of humerus, with internal fixation (H) (Anaes.) (Assist.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $876.40 **Benefit:** 75% = $657.30
Fee 48419	Osteotomy of distal tibia, for correction of deformity, without internal or external fixation, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of joint;

	(c) removal of bone; (d) synovectomy; —one bone (H) (Anaes.) (Assist.) **Fee:** $690.70 **Benefit:** 75% = $518.05
Fee 48420	Osteotomy of distal tibia, for correction of deformity, with internal or external fixation by any method, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of joint; (c) removal of bone; (d) synovectomy; —one bone (H) (Anaes.) (Assist.) **Fee:** $876.40 **Benefit:** 75% = $657.30
Fee 48421	Osteotomy of proximal tibia, to alter lower limb alignment or rotation (or both), with internal or external fixation (or both) (H) (Anaes.) (Assist.) (See para TN.8.168, TN.8.200, TN.8.196 of explanatory notes to this Category) **Fee:** $1,006.60 **Benefit:** 75% = $754.95
Fee 48422	Osteotomy of distal femur, to alter lower limb alignment or rotation (or both), with internal or external fixation (or both) (H) (Anaes.) (Assist.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $1,000.20 **Benefit:** 75% = $750.15
Fee 48423	Osteotomy of pelvis, in a patient aged 18 years or over, including any of the following (if performed): (a) associated intra-articular procedures; (b) bone grafting; (c) internal fixation (H) (Anaes.) (Assist.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $825.00 **Benefit:** 75% = $618.75
Fee 48424	Osteotomy of pelvis, in a patient aged less than 18 years, with application of hip spica, including internal fixation (if performed), other than a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) (See para TN.8.127, TN.8.168 of explanatory notes to this Category) **Fee:** $825.00 **Benefit:** 75% = $618.75
Fee 48426	Osteotomy of femur, in a patient aged 18 years or over, including either or both of the following (if performed): (a) bone grafting;

	(b) internal fixation (H) (Anaes.) (Assist.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $1,000.20 **Benefit:** 75% = $750.15
Fee 48427	Osteotomy of femur, in a patient aged less than 18 years, including internal fixation (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $1,000.20 **Benefit:** 75% = $750.15
Fee 48430	Excision of one or more osteophytes of the foot or ankle, or simple removal of bunion, including any of the following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; —each incision (H) (Anaes.) (Assist.) (See para TN.8.200, TN.8.201, TN.8.196 of explanatory notes to this Category) **Fee:** $293.85 **Benefit:** 75% = $220.40
Fee 48433	Treatment of non-union or malunion, with preservation of the joint, for ankle or hindfoot fracture, with internal or external fixation by any method, including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) excision of surrounding osteophytes; (d) osteotomy; (e) release of joint; (f) removal of bone; (g) removal of hardware; (h) synovectomy; —one bone (H) (Anaes.) (Assist.) **Fee:** $1,170.35 **Benefit:** 75% = $877.80

Fee 48435	Treatment of non-union or malunion, with preservation of the joint, for midfoot or forefoot fracture, with internal or external fixation by any method, including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) excision of surrounding osteophytes; (d) osteotomy; (e) release of joint; (f) removal of bone; (g) removal of hardware; (h) synovectomy; —one bone (H) (Anaes.) (Assist.) **Fee:** $618.65 **Benefit:** 75% = $464.00
Fee 50395	Osteotomy and distillation of greater trochanter, with internal fixation (H) (Anaes.) (Assist.) **Fee:** $1,000.20 **Benefit:** 75% = $750.15
	GROWTH PLATE PROCEDURES
Fee 48507	Epiphysiodesis of a long bone, in a patient less than 18 years of age (H) (Anaes.) (Assist.) **Fee:** $401.10 **Benefit:** 75% = $300.85
Fee 48509	Hemiepiphysiodesis, partial growth plate arrest using internal fixation, in a patient less than 18 years of age (H) (Anaes.) (Assist.) **Fee:** $360.95 **Benefit:** 75% = $270.75
Fee 48512	Epiphysiolysis, release of focal growth plate closure, in a patient less than 18 years of age (H) (Anaes.) (Assist.) **Fee:** $979.60 **Benefit:** 75% = $734.70
	SHOULDER
Fee 48900	Shoulder, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.) **Fee:** $309.20 **Benefit:** 75% = $231.90 85% = $262.85
Fee 48903	Shoulder, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (H) (Anaes.) (Assist.) **Fee:** $618.65 **Benefit:** 75% = $464.00
Fee 48906	Shoulder, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both—other than a service associated with a service to which item 48900 applies (H) (Anaes.) (Assist.) **Fee:** $618.65 **Benefit:** 75% = $464.00

Fee 48909	Shoulder, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, other than a service associated with a service to which item 48903 applies (H) (Anaes.) (Assist.) **Fee:** $825.00 **Benefit:** 75% = $618.75
Fee 48915	Shoulder, hemi-arthroplasty of (H) (Anaes.) (Assist.) **Fee:** $825.00 **Benefit:** 75% = $618.75
Fee 48918	Anatomic or reverse total shoulder replacement, including any of the following (if performed): (a) associated rotator cuff repair; (b) biceps tenodesis; (c) tuberosity osteotomy; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by open or arthroscopic means (H) (Anaes.) (Assist.) **Fee:** $1,649.95 **Benefit:** 75% = $1237.50
Fee 48921	Shoulder, total replacement arthroplasty, revision of (H) (Anaes.) (Assist.) **Fee:** $1,701.25 **Benefit:** 75% = $1275.95
Fee 48924	Revision of total shoulder replacement, including either or both of the following (if performed): (a) bone graft to humerus; (b) bone graft to scapula (H) (Anaes.) (Assist.) **Fee:** $1,959.20 **Benefit:** 75% = $1469.40
Fee 48927	Shoulder prosthesis, removal of (H) (Anaes.) (Assist.) **Fee:** $401.95 **Benefit:** 75% = $301.50
Fee 48939	Shoulder, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.) **Fee:** $1,185.75 **Benefit:** 75% = $889.35
Fee 48942	Arthrodesis of shoulder, with bone grafting or internal fixation, including either or both of the following (if performed): (a) removal of prosthesis; (b) synovectomy; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $1,546.65 **Benefit:** 75% = $1160.00
Fee 48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)

	Fee: $298.95 **Benefit:** 75% = $224.25
Fee 48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.) **Fee:** $670.25 **Benefit:** 75% = $502.70
Fee 48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.) **Fee:** $979.60 **Benefit:** 75% = $734.70
Fee 48954	Synovectomy of shoulder, performed as an independent procedure, including release of contracture (if performed), other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.) **Fee:** $1,031.10 **Benefit:** 75% = $773.35
Fee 48958	Joint stabilisation procedure for multi-directional instability of shoulder, anterior or posterior repair, by open or arthroscopic means, including labral repair or reattachment (if performed), excluding bone grafting and removal of hardware, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.) **Fee:** $1,185.75 **Benefit:** 75% = $889.35
Fee 48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (H) (Anaes.) (Assist.) **Fee:** $1,031.10 **Benefit:** 75% = $773.35
Fee 48972	Tenodesis of biceps, by open or arthroscopic means, performed as an independent procedure (H) (Anaes.) (Assist.) **Fee:** $474.20 **Benefit:** 75% = $355.65
Fee 48980	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the shoulder girdle (H) (Anaes.) (Assist.) **Fee:** $876.40 **Benefit:** 75% = $657.30
	ELBOW
Fee 48983	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the elbow (H) (Anaes.) (Assist.) **Fee:** $642.75 **Benefit:** 75% = $482.10
Fee 48986	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the forearm (H) (Anaes.) (Assist.) **Fee:** $876.40 **Benefit:** 75% = $657.30
Fee 49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (H) (Anaes.) (Assist.) **Fee:** $360.95 **Benefit:** 75% = $270.75

Fee 49104	Repair of one or more ligaments of the elbow, for acute instability—within 6 weeks after the time of injury (H) (Anaes.) (Assist.) **Fee:** $579.95 **Benefit:** 75% = $435.00
Fee 49105	Stabilisation of one or more ligaments of the elbow, for chronic instability, including harvesting of tendon graft—6 weeks or more after the time of injury (H) (Anaes.) (Assist.) **Fee:** $850.65 **Benefit:** 75% = $638.00
Fee 49106	ELBOW, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $1,031.10 **Benefit:** 75% = $773.35 85% = $937.90
Fee 49109	ELBOW, total synovectomy of (H) (Anaes.) (Assist.) **Fee:** $773.25 **Benefit:** 75% = $579.95
Fee 49112	Radial head replacement of elbow, other than a service associated with a service to which item 49115 applies (H) (Anaes.) (Assist.) **Fee:** $773.25 **Benefit:** 75% = $579.95
Fee 49115	Total or hemi humeral arthroplasty of elbow, excluding isolated radial head replacement and ligament stabilisation procedures, other than a service associated with a service to which item 49112 applies (H) (Anaes.) (Assist.) **Fee:** $1,237.20 **Benefit:** 75% = $927.90
Fee 49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (H) (Anaes.) (Assist.) **Fee:** $1,633.10 **Benefit:** 75% = $1224.85
Fee 49117	Revision of total replacement arthroplasty of elbow, including bone grafting and removal of prosthesis (H) (Anaes.) (Assist.) **Fee:** $1,959.75 **Benefit:** 75% = $1469.85
Fee 49118	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow (H) (Anaes.) (Assist.) **Fee:** $298.95 **Benefit:** 75% = $224.25
Fee 49121	Surgery of the elbow, by arthroscopic means, including any of the following (if performed): (a) chondroplasty; (b) drilling of defect; (c) osteoplasty; (d) removal of loose bodies; (e) release of contracture or adhesions; (f) treatment of epicondylitis; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow (H) (Anaes.) (Assist.)

	Fee: $670.25 **Benefit:** 75% = $502.70
Fee 49124	Excision of olecranon bursa, including bony prominence, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow (Anaes.) (Assist.) **Fee:** $406.90 **Benefit:** 75% = $305.20 85% = $345.90
	WRIST
Fee 49200	Wrist, arthrodesis of, with synovectomy if performed, with or without internal fixation of the radiocarpal joint (H) (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $896.95 **Benefit:** 75% = $672.75
Fee 49203	Limited fusion of wrist, with or without bone graft, including each of the following: (a) ligament or tendon transfers; (b) partial or total excision of one or more carpal bones; (c) rebalancing procedures; (d) synovectomy (H) (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $849.60 **Benefit:** 75% = $637.20
Fee 49206	Proximal row carpectomy of wrist, including either or both of the following (if performed): (a) styloidectomy; (b) synovectomy (H) (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $618.65 **Benefit:** 75% = $464.00
Fee 49209	Prosthetic replacement of wrist or distal radioulnar joint, including either or both of the following (if performed): (a) ligament realignment; (b) tendon realignment (H) (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $825.00 **Benefit:** 75% = $618.75
Fee 49210	Revision of total replacement arthroplasty of wrist or distal radioulnar joint, including any of the following (if performed): (a) ligament rebalancing; (b) removal of prosthesis;

	(c) tendon rebalancing (H) (Anaes.) (Assist.) **Fee:** $1,089.00 **Benefit:** 75% = $816.75
Fee 49212	Arthrotomy of wrist or distal radioulnar joint, including any of the following (if performed): (a) joint debridement; (b) removal of loose bodies; (c) synovectomy (H) (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $257.90 **Benefit:** 75% = $193.45
Fee 49213	Sauve-Kapandji procedure of distal radioulnar joint, including any of the following (if performed): a) radioulnar fusion; b) osteotomy; c) soft tissue reconstruction (Anaes.) (Assist.) **Fee:** $922.75 **Benefit:** 75% = $692.10 85% = $829.55
Fee 49215	Reconstruction of single or multiple ligaments or capsules of wrist, including any of the following (if performed): (a) arthrotomy; (b) ligament harvesting and grafting; (c) synovectomy; (d) tendon harvesting and grafting; (e) insertion of synthetic ligament substitute (H) (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $711.60 **Benefit:** 75% = $533.70
Fee 49218	Wrist, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy)—other than a service associated with another arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $298.95 **Benefit:** 75% = $224.25
Fee 49219	Diagnosis of carpometacarpal of thumb or joint of digit, by arthroscopic means, including biopsy (if performed) (H) (Anaes.) (Assist.) **Fee:** $298.95 **Benefit:** 75% = $224.25

Fee 49220	Treatment of carpometacarpal of thumb or joint of digit, by arthroscopic means—one joint (H) (Anaes.) (Assist.) **Fee:** $670.25 **Benefit:** 75% = $502.70
Fee 49221	Treatment of wrist, by arthroscopic means, including any of the following (if performed): (a) drilling of defect; (b) removal of loose bodies; (c) release of adhesions; (d) synovectomy; (e) debridement; (f) resection of dorsal or volar ganglia; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $670.25 **Benefit:** 75% = $502.70
Fee 49224	Osteoplasty of wrist, by arthroscopic means, including either or both of the following (if performed): (a) excision of the distal ulna; (b) total synovectomy; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint—2 or more distinct areas (H) (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $773.25 **Benefit:** 75% = $579.95
Fee 49227	Treatment of wrist by one of the following: (a) pinning of osteochondral fragment, by arthroscopic means; (b) stabilisation procedure for ligamentous disruption; (c) partial wrist fusion or carpectomy, by arthroscopic means; (d) fracture management; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $773.25 **Benefit:** 75% = $579.95
Fee 49230	Total, hemi or interpositional prosthetic replacement of carpal bone of wrist, for trauma or emergency, including all of the following:

	(a) ligament and tendon rebalancing procedures; (b) limited wrist fusions; (c) limited bone grafting (H) (Anaes.) (Assist.) **Fee:** $1,008.95 **Benefit:** 75% = $756.75
Fee 49233	Excisional arthroplasty of single (or part of) carpal bone of wrist, when transfers of ligaments or tendons, or rebalancing procedures, are not required, including all of the following: (a) radial styloidectomy; (b) ulnar styloidectomy; (c) proximal hamate; (d) partial scaphoid; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a distal radial ulnar joint reconstruction, a proximal row carpectomy or another wrist procedure—applicable once for a single operation (H) (Anaes.) (Assist.) **Fee:** $424.80 **Benefit:** 75% = $318.60
Fee 49236	Stabilisation of soft tissue of distal radioulnar joint, with or without ligament or tendon grafting, including either or both of the following (if performed): (a) graft harvest; (b) triangular fibrocartilage complex repair or reconstruction (H) (Anaes.) (Assist.) **Fee:** $640.45 **Benefit:** 75% = $480.35
Fee 49239	Excision of pisiform or hook of hamate, including release of ulnar nerve (if performed) (H) (Anaes.) (Assist.) **Fee:** $318.60 **Benefit:** 75% = $238.95
	HIP
Fee 47491 S	Combined anterior and posterior pelvic ring disruption, including sacroiliac joint disruption, treatment of fracture by open reduction and internal fixation of both anterior and posterior ring segments (H) (Anaes.) (Assist.) **Fee:** $1,701.25 **Benefit:** 75% = $1275.95
Fee 49300	Sacro-iliac joint—arthrodesis of (H) (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 49303	Arthrotomy of hip, by open procedure, including any of the following (if performed): (a) lavage;

	(b) drainage; (c) biopsy (H) (Anaes.) (Assist.) (See para TN.8.127 of explanatory notes to this Category) **Fee:** $598.00 **Benefit:** 75% = $448.50
Fee 49306	Hip, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.) **Fee:** $1,185.75 **Benefit:** 75% = $889.35
Fee 49309	Arthrectomy or excision arthroplasty (Girdlestone) of hip, other than a service performed: (a) for the purpose of implant removal; or (b) as stage 1 of a 2-stage procedure (H) (Anaes.) (Assist.) **Fee:** $825.00 **Benefit:** 75% = $618.75
Fee 49315	Hip, arthroplasty of, unipolar or bipolar (H) (Anaes.) (Assist.) **Fee:** $928.00 **Benefit:** 75% = $696.00
Fee 49318	Total arthroplasty of hip, including minor bone grafting (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $1,443.35 **Benefit:** 75% = $1082.55
Fee 49319	Bilateral total arthroplasty of hip, including minor bone grafting (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $2,535.80 **Benefit:** 75% = $1901.85
Fee 49321	Total arthroplasty of hip, with internal fixation, including either or both of the following (if performed): (a) structural bone graft; (b) insertion of synthetic substitutes or metal augments; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $1,753.05 **Benefit:** 75% = $1314.80
Fee 49360	Diagnostic arthroscopy of hip, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure of the hip joint by arthroscopic means (H) (Anaes.) (Assist.) **Fee:** $376.75 **Benefit:** 75% = $282.60
Fee 49363	Treatment of hip, by arthroscopic means, with synovial biopsy, including any procedures to treat bone or soft tissue in the same area (if performed), other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing:

	(a) a procedure of the hip joint by arthroscopic means; or (b) surgery for femoroacetabular impingement (H) (Anaes.) (Assist.) **Fee:** $453.65 **Benefit:** 75% = $340.25
Fee 49366	Treatment of hip, by arthroscopic means, including any procedures to treat bone or soft tissue in the same area (if performed), other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing: (a) a procedure of the hip joint by arthroscopic means; or (b) surgery for femoroacetabular impingement (H) (Anaes.) (Assist.) (See para TN.8.127 of explanatory notes to this Category) **Fee:** $670.25 **Benefit:** 75% = $502.70
Fee 49372	Revision arthroplasty of hip, with exchange of head or liner (or both) (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $1,010.25 **Benefit:** 75% = $757.70
Fee 49374	Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including minor bone grafting (if performed) (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $1,876.25 **Benefit:** 75% = $1407.20
Fee 49376	Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including major bone grafting (if performed) (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,309.30 **Benefit:** 75% = $1732.00
Fee 49378	Revision arthroplasty of hip, with revision of femoral component (if there is no requirement for femoral osteotomy), including minor bone grafting (if performed) (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,020.50 **Benefit:** 75% = $1515.40
Fee 49380	Revision arthroplasty of hip, with revision of femoral and acetabular components (if femoral osteotomy is not required), including minor bone grafting (if performed) (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,453.60 **Benefit:** 75% = $1840.20
Fee 49382	Revision arthroplasty of hip, with revision of femoral and acetabular components (if femoral osteotomy is not required), including major bone grafting (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $3,175.25 **Benefit:** 75% = $2381.45
Fee 49384	Revision arthroplasty of hip, for pelvic discontinuity, with revision of acetabular component (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $3,752.55 **Benefit:** 75% = $2814.45

	Revision arthroplasty of hip, with revision of femoral component with femoral osteotomy, including minor bone grafting (if performed) (H) (Anaes.) (Assist.)
Fee 49386	(See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,597.95 **Benefit:** 75% = $1948.50
	Revision arthroplasty of hip, including: (a) revision of both of the following: (i) femoral component with femoral osteotomy; (ii) acetabular component; and (b) minor bone grafting (if performed) (H) (Anaes.) (Assist.)
Fee 49388	(See para TN.8.191 of explanatory notes to this Category) **Fee:** $3,030.95 **Benefit:** 75% = $2273.25
	Revision arthroplasty of hip, including: (a) revision of both of the following: (i) femoral component with femoral osteotomy; (ii) acetabular component; and (b) major bone grafting (H) (Anaes.) (Assist.)
Fee 49390	(See para TN.8.191 of explanatory notes to this Category) **Fee:** $3,608.25 **Benefit:** 75% = $2706.20
	Revision arthroplasty of hip, including: (a) either: (i) revision of femoral component with femoral osteotomy; or (ii) proximal femoral replacement; and (b) revision of acetabular component for pelvic discontinuity (H) (Anaes.) (Assist.)
Fee 49392	(See para TN.8.191 of explanatory notes to this Category) **Fee:** $5,051.55 **Benefit:** 75% = $3788.70
	Revision arthroplasty of hip, including: (a) replacement of proximal femur; and (b) revision of the acetabular component; and
Fee 49394	(c) bone grafting (if performed)

	(H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $4,329.85 **Benefit:** 75% = $3247.40
Fee 49396	Revision arthroplasty of hip, including: (a) removal of prosthesis as stage 1 of a 2-stage revision arthroplasty or as a definitive stage procedure; and (b) insertion of temporary prosthesis (if performed) (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,886.55 **Benefit:** 75% = $2164.95
Fee 49398	Revision arthroplasty of hip, including: (a) revision of femoral component for periprosthetic fracture; and (b) internal fixation; and (c) bone grafting (if performed) (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,165.00 **Benefit:** 75% = $1623.75
Fee 50107	Stabilisation of joint of hip, by open means, including any of the following (if performed): (a) repair of capsule; (b) labrum; (c) capsulorraphy; (d) repair of ligament; (e) internal fixation; other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.) **Fee:** $515.50 **Benefit:** 75% = $386.65
	KNEE
Fee 47592	Repair or reconstruction (or both) of acute traumatic chondral injury to the distal femoral or proximal tibial articular surfaces of the knee, when chondral or osteochondral implants or transfers are utilised (H) (Anaes.) (Assist.) **Fee:** $357.05 **Benefit:** 75% = $267.80
Fee 49500	Knee, arthrotomy of, involving one or more of capsular release, biopsy or lavage, or removal of loose body or foreign body (H) (Anaes.) (Assist.) **Fee:** $412.40 **Benefit:** 75% = $309.30

Fee 49503	Arthrotomy of knee, including one of the following: (a) meniscal surgery; (b) repair of collateral or cruciate ligament; (c) patellectomy; (d) single transfer of ligament or tendon; (e) repair or replacement of chondral or osteochondral surface (excluding prosthetic replacement); other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.) **Fee:** $536.20 **Benefit:** 75% = $402.15
Fee 49506	Arthrotomy of knee, including 2 or more of the following: (a) meniscal surgery; (b) repair of collateral or cruciate ligament; (c) patellectomy; (d) single transfer of ligament or tendon; (e) repair or replacement of chondral or osteochondral surface (excluding prosthetic replacement); other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.) **Fee:** $804.35 **Benefit:** 75% = $603.30
Fee 49509	Total synovectomy of knee, by open procedure, other than a service performed in association with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroplasty (H) (Anaes.) (Assist.) **Fee:** $825.00 **Benefit:** 75% = $618.75
Fee 49512	Primary or revision arthrodesis of knee, including arthrodesis (H) (Anaes.) (Assist.) **Fee:** $1,443.35 **Benefit:** 75% = $1082.55
Fee 49515	Removal of cemented or uncemented knee prosthesis, performed as the first stage of a 2-stage procedure; including: (a) removal of associated cement; and (b) insertion of spacer (if required) (H) (Anaes.) (Assist.) **Fee:** $928.00 **Benefit:** 75% = $696.00
Fee 49516	Bilateral unicompartmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.) **Fee:** $2,312.15 **Benefit:** 75% = $1734.15

Fee 49517	Unicompartmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.) **Fee:** $1,321.25 **Benefit:** 75% = $990.95
Fee 49518	Total replacement arthroplasty of knee, including either or both of the following (if performed): (a) revision of patello-femoral joint replacement to total knee replacement; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $1,443.35 **Benefit:** 75% = $1082.55
Fee 49519	Bilateral total replacement arthroplasty of knee, including patellar resurfacing, other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $2,535.80 **Benefit:** 75% = $1901.85
Fee 49521	Complex primary arthroplasty of knee, with revision of components to femur or tibia, including either or both of the following (if performed): (a) ligament reconstruction; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $1,753.05 **Benefit:** 75% = $1314.80
Fee 49524	Complex primary arthroplasty of knee, with revision of components to femur and tibia, including either or both of the following (if performed): (a) ligament reconstruction; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $2,062.30 **Benefit:** 75% = $1546.75
Fee 49525	Revision of uni-compartmental arthroplasty of the knee, with femoral or tibial components (or both) with uni-compartmental implants, other than a service associated with a service to which: (a) item 48245, 48248, 48251, 48254 or 48257 applies; or (b) another item in this Group applies if the service described in the other item is for the purpose of performing surgery on a knee (H) (Anaes.) (Assist.) **Fee:** $1,753.05 **Benefit:** 75% = $1314.80
Fee 49527	Minor revision of total or partial replacement of knee, including either or both of the following: (a) exchange of polyethylene component (including uni);

	(b) insertion of patellar component; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $1,443.35 **Benefit:** 75% = $1082.55
Fee 49530	Revision of total or partial replacement of knee, with exchange of femoral or tibial component: (a) excluding revision of unicompartmental with unicompartmental implants; and (b) including patellar resurfacing (if performed); other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $2,165.50 **Benefit:** 75% = $1624.15
Fee 49533	Revision of total or partial replacement of knee, with exchange of femoral and tibial components, excluding revision of unicompartmental with unicompartmental implants, including patellar resurfacing (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $2,784.65 **Benefit:** 75% = $2088.50
Fee 49534	Replacement of patella and trochlea of patello-femoral joint of knee, performed as a primary procedure (H) (Anaes.) (Assist.) **Fee:** $796.55 **Benefit:** 75% = $597.45
Fee 49536	Either: (a) repair of cruciate ligaments of knee; or (b) repair or reconstruction of collateral ligaments of knee; by open or arthroscopic means, including either or both of the following (if performed): (c) graft harvest; (d) intraarticular knee surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.) (See para TN.8.182 of explanatory notes to this Category) **Fee:** $1,031.10 **Benefit:** 75% = $773.35
Fee 49542	Reconstruction of anterior or posterior cruciate ligament of knee, by open or arthroscopic means, including any of the following (if performed): (a) graft harvest; (b) donor site repair; (c) meniscal repair; (d) collateral ligament repair;

	(e) extra-articular tenodesis; (f) any other associated intra-articular surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.) (See para TN.8.182 of explanatory notes to this Category) **Fee:** $1,443.35 **Benefit:** 75% = $1082.55
Fee 49544	Reconstruction of 2 or more cruciate or collateral ligaments of knee, by open or arthroscopic means, including any of the following (if performed): (a) ligament repair; (b) graft harvest donor site repair; (c) meniscal repair; (d) any other associated intra-articular surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.) **Fee:** $1,680.40 **Benefit:** 75% = $1260.30
Fee 49548	Knee, revision of patello-femoral stabilisation (H) (Anaes.) (Assist.) **Fee:** $1,031.10 **Benefit:** 75% = $773.35
Fee 49551	Knee, revision of procedures to which item 49536 or 49542 applies (H) (Anaes.) (Assist.) **Fee:** $1,443.35 **Benefit:** 75% = $1082.55
Fee 49554	Revision of total replacement of knee, by anatomic specific allograft of tibia or femur, other than a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) **Fee:** $2,062.30 **Benefit:** 75% = $1546.75
Fee 49564	Stabilisation of patellofemoral joint of knee, by combined open and arthroscopic means, including either or both of the following (if performed): (a) medial soft tissue reconstruction and tendon transfer; (b) tibial tuberosity transfer with bone graft and internal fixation; other than a service associated a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.) **Fee:** $1,006.60 **Benefit:** 75% = $754.95
Fee 49565	Reconstruction of patellofemoral joint of knee, by combined open and arthroscopic means, including: (a) both of the following: (i) medial soft tissue reconstruction;

	(ii) tibial tuberosity transfer; and (b) any of the following (if performed): (i) bone graft; (ii) internal fixation; (iii) trochleoplasty; other than a service associated a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.) **Fee:** $1,444.75 **Benefit:** 75% = $1083.60
Fee 49569	Knee, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (H) (Anaes.) (Assist.) **Fee:** $825.00 **Benefit:** 75% = $618.75
Fee 49570	Diagnosis of knee, by arthroscopic means, when the pre-procedure diagnosis is undetermined, including either or both of the following (if performed): (a) biopsy; (b) lavage (H) (Anaes.) (Assist.) (See para TN.8.183 of explanatory notes to this Category) **Fee:** $298.95 **Benefit:** 75% = $224.25
Fee 49572	Partial meniscectomy of knee, by arthroscopic means, for atraumatic meniscus tear, other than a service to which another item of this Schedule applies if the service described in the other item is for the purpose of treating osteoarthritis (H) (Anaes.) (Assist.) (See para TN.8.183 of explanatory notes to this Category) **Fee:** $727.50 **Benefit:** 75% = $545.65
Fee 49574	Removal of loose bodies of knee, by arthroscopic means—one or more bodies (H) (Anaes.) (Assist.) (See para TN.8.183 of explanatory notes to this Category) **Fee:** $727.50 **Benefit:** 75% = $545.65
Fee 49576	Repair of chondral lesion of knee, by arthroscopic means, including either or both of the following (if performed): (a) microfracture; (b) microdrilling; other than a service performed in combination with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing chondral or osteochondral grafts (H) (Anaes.) (Assist.) (See para TN.8.183 of explanatory notes to this Category) **Fee:** $727.50 **Benefit:** 75% = $545.65

	Release of soft tissue, lateral release or osteoplasty of knee, by arthroscopic means, other than a service performed in combination with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of stabilising the patellofemoral joint of the knee (H) (Anaes.) (Assist.)
Fee 49578	(See para TN.8.183 of explanatory notes to this Category) **Fee:** $727.50 **Benefit:** 75% = $545.65
	Partial meniscectomy of knee, by arthroscopic means, for traumatic meniscus tear (H) (Anaes.) (Assist.)
Fee 49580	(See para TN.8.183 of explanatory notes to this Category) **Fee:** $727.50 **Benefit:** 75% = $545.65
	Meniscal repair of knee, by arthroscopic means (H) (Anaes.) (Assist.)
Fee 49582	(See para TN.8.183 of explanatory notes to this Category) **Fee:** $849.45 **Benefit:** 75% = $637.10
	Chondral, osteochondral or meniscal graft of knee, by arthroscopic means (H) (Anaes.) (Assist.)
Fee 49584	(See para TN.8.183 of explanatory notes to this Category) **Fee:** $849.45 **Benefit:** 75% = $637.10
	Synovectomy of knee, by arthroscopic means, for neoplasia or inflammatory arthropathy, other than a service to which another item of this Schedule applies if the service described in the other item is for the purpose of treating uncomplicated osteoarthritis (Anaes.) (Assist.)
Fee 49586	(See para TN.8.183 of explanatory notes to this Category) **Fee:** $849.45 **Benefit:** 75% = $637.10 85% = $756.25
	Excision of ganglion, cyst or bursa of knee, by open or arthroscopic means, performed as an independent procedure, other than a service associated with a service to which another item in this Group applies (Anaes.) (Assist.)
Fee 49590	(See para TN.8.183 of explanatory notes to this Category) **Fee:** $406.90 **Benefit:** 75% = $305.20 85% = $345.90
	ANKLE
	Surgery of ankle joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item in this Group applies if the service described in the other item is for the purpose of performing a procedure on the ankle by arthroscopic means (H) (Anaes.) (Assist.)
Fee 49703	(See para TN.8.202, TN.8.196 of explanatory notes to this Category) **Fee:** $670.25 **Benefit:** 75% = $502.70
Amend Fee 49706	Arthrotomy of joint of ankle, including removal of loose bodies and joint debridement, including release of joint contracture (if performed) (H) (Anaes.) (Assist.) (See para TN.8.223 of explanatory notes to this Category)

	Fee: $360.95 **Benefit:** 75% = $270.75
	Stabilisation of ligament of ankle or subtalar joint (or both), including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) joint debridement; —one ligament complex, each incision (H) (Anaes.) (Assist.)
Fee 49709	(See para TN.8.223, TN.8.195 of explanatory notes to this Category) **Fee:** $773.25 **Benefit:** 75% = $579.95
	Arthrodesis of ankle, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)
Fee 49712	(See para TN.8.200 of explanatory notes to this Category) **Fee:** $1,031.10 **Benefit:** 75% = $773.35
	Total replacement of ankle, with prosthetic replacement of ankle joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)
Fee 49715	(See para TN.8.201 of explanatory notes to this Category) **Fee:** $1,237.20 **Benefit:** 75% = $927.90
	Revision of total ankle replacement: (a) including either: (i) exchange of tibial or talar components (or both) and plastic inserts; or
Fee 49716	(ii) removal of tibial or talar components (or both) and plastic inserts; and

	(b) including any of the following (if performed): (i) insertion of cement spacer for infection; (ii) capsulotomy; (iii) joint release; (iv) neurolysis; (v) debridement of cysts; (vi) synovectomy; (vii) joint debridement other than a service associated with a service to which 30023 applies. (H) (Anaes.) (Assist.) (See para TN.8.201 of explanatory notes to this Category) **Fee:** $1,633.10 **Benefit:** 75% = $1224.85
Fee 49717	Revision of total ankle replacement: (a) including either: (i) exchange of tibial and talar components; or (ii) removal of tibial and talar components and conversion to ankle arthrodesis; and (b) including both of the following (iii) internal or external fixation, by any means; (iv) major bone grafting; and (c) including any of the following (if performed): (i) capsulotomy; (ii) joint release; (iii) neurolysis; (iv) debridement and extensive grafting of cysts; (v) synovectomy; (vi) joint debridement; other than a service associated with a service to which item 30023, 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) (See para TN.8.201 of explanatory notes to this Category) **Fee:** $1,959.75 **Benefit:** 75% = $1469.85

Fee 49718	Primary repair of major tendon of ankle, by any method, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy —one tendon (H) (Anaes.) (Assist.) **Fee:** $412.40 **Benefit:** 75% = $309.30
Fee 49724	Reconstruction of major tendon of ankle, by any method, including any of the following (if performed): (a) synovial biopsy; (b) synovectomy; (c) adjacent tendon transfer; (d) turn down flaps; other than a service associated with a service to which item 49718 applies (H) (Anaes.) (Assist.) (See para TN.8.204 of explanatory notes to this Category) **Fee:** $721.90 **Benefit:** 75% = $541.45
Fee 49727	Lengthening of major tendon of ankle, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy (H) (Anaes.) (Assist.) (See para TN.8.204 of explanatory notes to this Category) **Fee:** $309.20 **Benefit:** 75% = $231.90
Fee 49728	Lengthening of Achilles' tendon, by any method, with gastro-soleus lengthening for the correction of equinous deformity, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; other than a service associated with a service to which item 49727 applies (H) (Anaes.) (Assist.) (See para TN.8.204 of explanatory notes to this Category) **Fee:** $618.50 **Benefit:** 75% = $463.90
Fee 49740	Revision of arthrodesis of ankle, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy;

	(d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which 30023 applies (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $1,546.75 **Benefit:** 75% = $1160.10
Fee 49742	Arthrodesis of extended ankle and hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $1,460.15 **Benefit:** 75% = $1095.15
Fee 49744	Revision of arthrodesis of extended ankle and hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which 30023 applies (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $2,190.25 **Benefit:** 75% = $1642.70
Fee 49771	Synovectomy of major tendon of ankle, for extensive synovitis by any method, including any of the following (if performed):

	(a) tenolysis; (b) debridement of ligament or tendon (or both); (c) release of ligament or tendon (or both); (d) excision of tubercule or osteophyte; (e) reconstruction of tendon retinaculum; (f) neurolysis; other than a service associated with a service to which item 30023 applies—each incision (H) (Anaes.) (Assist.) **Fee:** $406.90 **Benefit:** 75% = $305.20
Fee 49782	Revision of total ankle replacement, including: (a) bone grafting of perioperative cysts to the tibia or talus (or both); and (b) retention of implants; and (c) any of the following (if performed): (i) capsulotomy; (ii) joint release; (iii) neurolysis; (iv) debridement and grafting of cysts; (v) synovectomy; (vi) joint debridement; other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.) **Fee:** $619.25 **Benefit:** 75% = $464.45
Fee 49814	Reconstruction of major tendon of ankle, by any method, including: (a) osteotomy of hindfoot, with internal fixation; and (b) lengthening of major tendon of ankle; and (c) any of the following (if performed): (i) synovial biopsy; (ii) synovectomy; (iii) adjacent tendon transfer; (iv) turn down flaps;

	other than a service associated with a service to which item 49718 applies (H) (Anaes.) (Assist.) (See para TN.8.200, TN.8.204 of explanatory notes to this Category) **Fee:** $1,082.80 **Benefit:** 75% = $812.10
Fee 49884	Complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of ankle, hindoot or midfoot joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) capsular or ligament repair; (vi) skin closure, by any method; other than a service associated with a service to which item 30023 applies—each incision (H) (Anaes.) (Assist.) **Fee:** $406.90 **Benefit:** 75% = $305.20
Fee 49890	Revision of complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of ankle, hindoot or midfoot joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) capsular or ligament repair; (vi) skin closure, by any method; other than a service associated with a service to which item 30023 or 49884 applies—each incision (H) (Anaes.) (Assist.) **Fee:** $549.25 **Benefit:** 75% = $411.95
	FOOT
Fee 49730	Surgery of joint of hindfoot (other than ankle) or first metatarsophalangeal joint, by arthroscopic means, including any of the following (if performed):

	(a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the ankle by arthroscopic means—one joint (H) (Anaes.) (Assist.) (See para TN.8.201, TN.8.202 of explanatory notes to this Category) **Fee:** $670.25 **Benefit:** 75% = $502.70
Fee 49732	Endoscopy of large tendons of foot, including any of the following (if performed): (a) debridement of tendon and sheath; (b) removal of loose bodies; (c) synovectomy; (d) excision of tendon impingement; other than a service associated with a service to which item 49718 or 49724 applies (H) (Anaes.) (Assist.) (See para TN.8.201, TN.8.202 of explanatory notes to this Category) **Fee:** $670.25 **Benefit:** 75% = $502.70
Fee 49734	Arthrotomy of hindfoot, midfoot or metatarsophalangeal joint, including: (a) removal of loose bodies; and (b) either or both of the following: (i) joint debridement; (ii) release of joint contracture; —each incision (H) (Anaes.) (Assist.) (See para TN.8.201, TN.8.223 of explanatory notes to this Category) **Fee:** $360.95 **Benefit:** 75% = $270.75
Fee 49736	Transfer of major tendon of foot and ankle, including: (a) split or whole transfer to contralateral side of foot; and (b) passage of posterior or anterior tendon to, or through, interosseous membrane; and (c) any of the following (if performed): (i) synovial biopsy; (ii) synovectomy;

	(iii) tendon lengthening; (iv) insetting of tendon (H) (Anaes.) (Assist.) (See para TN.8.204 of explanatory notes to this Category) **Fee:** $721.90 **Benefit:** 75% = $541.45
Fee 49738	Stabilisation of ligament of talonavicular or metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement (H) (Anaes.) (Assist.) **Fee:** $515.50 **Benefit:** 75% = $386.65
Fee 49760	Arthroereisis of subtalar joint, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $386.70 **Benefit:** 75% = $290.05
Fee 49761	Stabilisation of metatarsophalangeal joint at metatarsal, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —one metatarsal (H) (Anaes.) (Assist.)

	Fee: $567.10 **Benefit:** 75% = $425.35
Fee 49762	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —2 metatarsals (H) (Anaes.) (Assist.) **Fee:** $629.30 **Benefit:** 75% = $472.00
Fee 49763	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —3 metatarsals (H) (Anaes.) (Assist.) **Fee:** $691.55 **Benefit:** 75% = $518.70
Fee 49764	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer;

	(f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —4 metatarsals (H) (Anaes.) (Assist.) **Fee:** $753.80 **Benefit:** 75% = $565.35
Fee 49765	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —5 metatarsals (H) (Anaes.) (Assist.) **Fee:** $815.95 **Benefit:** 75% = $612.00
Fee 49766	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —6 metatarsals (H) (Anaes.) (Assist.) **Fee:** $878.25 **Benefit:** 75% = $658.70
Fee 49767	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy;

	(b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —7 metatarsals (H) (Anaes.) (Assist.) **Fee:** $940.50 **Benefit:** 75% = $705.40
Fee 49768	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —8 metatarsals (H) (Anaes.) (Assist.) **Fee:** $1,002.70 **Benefit:** 75% = $752.05
Fee 49769	Unilateral correction of hallux valgus or varus deformity, by osteotomy of first metatarsal and proximal phalanx of first toe, with internal fixation of both bones, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) **Fee:** $992.45 **Benefit:** 75% = $744.35

Fee 49770	Bilateral correction of hallux valgus or varus deformity, by osteotomy of first metatarsal and proximal phalanx of first toe, with internal fixation of both bones, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) **Fee:** $1,649.60 **Benefit:** 75% = $1237.20
Fee 49772	Excision of rheumatoid nodules or gouty tophi, excluding aftercare, including any of the following (if performed): (a) capsulotomy; (b) debridement of ligament or tendon (or both); (c) release of ligament or tendon (or both); (d) excision of tubercle or osteophyte; —each incision (H) (Anaes.) (Assist.) **Fee:** $359.10 **Benefit:** 75% = $269.35
Fee 49773	Revision of excision of intermetatarsal or digital neuroma, including any of the following (if performed): (a) release of tissues; (b) excision of bursae; (c) neurolysis; other than a service associated with a service to which item 30023 applies—one web space (H) (Anaes.) (Assist.) **Fee:** $445.05 **Benefit:** 75% = $333.80
Fee 49774	Release of tarsal tunnel, including any of the following (if performed): (a) release of ligaments; (b) synovectomy; (c) neurolysis; other than a service associated with a service to which item 30023 applies—one foot (H) (Anaes.) (Assist.) **Fee:** $303.15 **Benefit:** 75% = $227.40

	Revision of release of tarsal tunnel, including any of the following (if performed): (a) release of ligaments; (b) synovectomy; (c) neurolysis; other than a service associated with a service to which item 30023 applies—one foot (H) (Anaes.) (Assist.)
Fee 49775	**Fee:** $409.25 **Benefit:** 75% = $306.95
	Revision of arthrodesis of joint of hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which item 30023 applies—may only be claimed once per joint (H) (Anaes.) (Assist.)
Fee 49776	(See para TN.8.200, TN.8.224 of explanatory notes to this Category) **Fee:** $1,287.30 **Benefit:** 75% = $965.50
	Arthrodesis of joint of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; —one joint (H) (Anaes.) (Assist.)
Fee 49777	(See para TN.8.200 of explanatory notes to this Category) **Fee:** $762.25 **Benefit:** 75% = $571.70
	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy;
Fee 49778	(b) joint release;

	(c) synovectomy; (d) removal of osteophytes at joints; —2 joints (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $1,143.40 **Benefit:** 75% = $857.55
Fee 49779	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; —3 joints (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $1,333.90 **Benefit:** 75% = $1000.45
Fee 49780	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; —4 joints (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $1,524.40 **Benefit:** 75% = $1143.30
Fee 49781	Revision of arthrodesis of joint of midfoot, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of ostephytes at joint; (e) removal of hardware; (f) osteotomy of non-union or malunion; —one joint (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category)

	Fee: $1,143.40 **Benefit:** 75% = $857.55
Fee 49784	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —4 joints (H) (Anaes.) (Assist.) **Fee:** $949.05 **Benefit:** 75% = $711.80
Fee 49785	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —5 joints (H) (Anaes.) (Assist.) **Fee:** $1,067.60 **Benefit:** 75% = $800.70
Fee 49786	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —6 joints (H) (Anaes.) (Assist.) **Fee:** $1,186.15 **Benefit:** 75% = $889.65
Fee 49787	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy;

	(b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —7 joints (H) (Anaes.) (Assist.) **Fee:** $1,304.70 **Benefit:** 75% = $978.55
Fee 49788	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —8 joints (H) (Anaes.) (Assist.) **Fee:** $1,423.25 **Benefit:** 75% = $1067.45
Fee 49789	Bilateral arthrodesis of first metatarsophalangeal joint, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $1,224.20 **Benefit:** 75% = $918.15
Fee 49790	Revision of arthrodesis of first metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of exostosis at joint; (e) removal of hardware;

	(f) osteotomy of non-union or malunion (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $1,063.30 **Benefit:** 75% = $797.50
Fee 49791	Arthrodesis of hallux interphalangeal or lesser metatarsophalangeal joint, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $482.10 **Benefit:** 75% = $361.60
Fee 49792	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —one or 2 toes (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $541.50 **Benefit:** 75% = $406.15
Fee 49793	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —3 toes (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $631.75 **Benefit:** 75% = $473.85

	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —4 toes (H) (Anaes.) (Assist.)
Fee 49794	(See para TN.8.200 of explanatory notes to this Category) **Fee:** $721.95 **Benefit:** 75% = $541.50
	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —5 toes (H) (Anaes.) (Assist.)
Fee 49795	(See para TN.8.200 of explanatory notes to this Category) **Fee:** $812.20 **Benefit:** 75% = $609.15
	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —6 toes (H) (Anaes.) (Assist.)
Fee 49796	(See para TN.8.200 of explanatory notes to this Category) **Fee:** $902.45 **Benefit:** 75% = $676.85
	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method;
Fee 49797	

	(b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —7 toes (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $992.70 **Benefit:** 75% = $744.55
Fee 49798	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —8 toes (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $1,082.95 **Benefit:** 75% = $812.25
Fee 49800	Primary repair of flexor or extensor tendon of foot, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; —one toe (Anaes.) (Assist.) **Fee:** $144.35 **Benefit:** 75% = $108.30 85% = $122.70
Fee 49803	Secondary repair of flexor or extensor tendon of foot, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; —one toe (Anaes.) (Assist.) (See para TN.8.204 of explanatory notes to this Category) **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80
Fee 49806	Subcutaneous tenotomy of foot, by small percutaneous incisions—one or more tendons (Anaes.) (See para TN.8.204 of explanatory notes to this Category) **Fee:** $144.35 **Benefit:** 75% = $108.30 85% = $122.70

	Open tenotomy or lengthening of foot, by open incision, with or without tenoplasty, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; —one toe (Anaes.) (Assist.)
Fee 49809	(See para TN.8.223, TN.8.204 of explanatory notes to this Category) **Fee:** $237.10 **Benefit:** 75% = $177.85 85% = $201.55
	Advancement of tendon or ligament transfer of foot, including: (a) side to side transfer, harvesting and transfer for ligament or minor foot tendon reconstruction; and (b) either or both of the following (if performed): (i) synovial biopsy; (ii) synovectomy; —one major tendon or toe (H) (Anaes.) (Assist.)
Fee 49812	(See para TN.8.201, TN.8.223, TN.8.204 of explanatory notes to this Category) **Fee:** $474.20 **Benefit:** 75% = $355.65
	Triple arthrodesis of hindfoot joints, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints (H) (Anaes.) (Assist.)
Fee 49815	(See para TN.8.200 of explanatory notes to this Category) **Fee:** $1,501.90 **Benefit:** 75% = $1126.45
	Release of plantar fascia, including excision of calcaneal spur (if performed) (H) (Anaes.) (Assist.)
Fee 49818	(See para TN.8.223, TN.8.197 of explanatory notes to this Category) **Fee:** $298.95 **Benefit:** 75% = $224.25
	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy;
Fee 49821	(d) local tendon transfer;

	(e) joint debridement —one joint (H) (Anaes.) (Assist.) (See para TN.8.201, TN.8.194 of explanatory notes to this Category) **Fee:** $474.20 **Benefit:** 75% = $355.65
Fee 49824	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —2 joints (H) (Anaes.) (Assist.) (See para TN.8.194 of explanatory notes to this Category) **Fee:** $830.15 **Benefit:** 75% = $622.65
Fee 49827	Unilateral correction of hallux valgus or varus deformity of the foot, by local tendon transfer, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) (See para TN.8.201, TN.8.223, TN.8.194, TN.8.196 of explanatory notes to this Category) **Fee:** $515.50 **Benefit:** 75% = $386.65
Fee 49830	Bilateral correction of hallux valgus or varus deformity of the foot, by local tendon transfer, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) (See para TN.8.201, TN.8.223, TN.8.223, TN.8.194 of explanatory notes to this Category)

	Fee: $902.20 **Benefit:** 75% = $676.65
	Unilateral correction of hallux valgus or varus deformity of the foot, by osteotomy of first metatarsal, without internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)
Fee 49833	(See para TN.8.201, TN.8.223, TN.8.194, TN.8.196 of explanatory notes to this Category) **Fee:** $567.10 **Benefit:** 75% = $425.35
	Bilateral correction of hallux valgus or varus deformity of the foot by osteotomy of first metatarsal, without internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)
Fee 49836	(See para TN.8.201, TN.8.223, TN.8.194, TN.8.196 of explanatory notes to this Category) **Fee:** $979.60 **Benefit:** 75% = $734.70
	Unilateral correction of hallux valgus or varus deformity of the foot, by osteotomy of first metatarsal, with internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)
Fee 49837	(See para TN.8.201, TN.8.223, TN.8.194, TN.8.196 of explanatory notes to this Category) **Fee:** $708.90 **Benefit:** 75% = $531.70

	Bilateral correction of hallux valgus or varus deformity of the foot by osteotomy of first metatarsal, with internal fixation or arthrodesis of first metatarsophalangeal joint, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)
Fee 49838	(See para TN.8.201, TN.8.223, TN.8.194, TN.8.196 of explanatory notes to this Category) **Fee:** $1,224.20 **Benefit:** 75% = $918.15
	Total replacement of first metatarsophalangeal joint, with replacement of both joint surfaces, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.)
Fee 49839	(See para TN.8.201 of explanatory notes to this Category) **Fee:** $567.10 **Benefit:** 75% = $425.35
	Unilateral arthrodesis of first metatarsophalangeal joint, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints (H) (Anaes.) (Assist.)
Fee 49845	(See para TN.8.200, TN.8.223 of explanatory notes to this Category) **Fee:** $708.90 **Benefit:** 75% = $531.70
	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal (or both) joints of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy;
Fee 49851	(c) tendon lengthening;

	(d) joint release; (e) synovectomy; (f) removal of osteophytes at joints; —one toe (H) (Anaes.) (Assist.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $474.20 **Benefit:** 75% = $355.65
Fee 49854	Radical plantar fasciotomy or fasciectomy, with extensive incision into foot and excision of fascia, including excision of calcaneal spur (if performed), other than a service associated with a service to which 49818 applies (H) (Anaes.) (Assist.) (See para TN.8.223, TN.8.197 of explanatory notes to this Category) **Fee:** $412.40 **Benefit:** 75% = $309.30
Fee 49857	Hemi joint replacement of first or lesser metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.) (See para TN.8.201 of explanatory notes to this Category) **Fee:** $381.50 **Benefit:** 75% = $286.15
Fee 49860	Synovectomy of metatarsophalangeal joints, including any of the following (if performed): (a) capsulotomy; (b) debridement; (c) release of ligament or tendon (or both); —one or more joints on one foot (H) (Anaes.) (Assist.) (See para TN.8.201 of explanatory notes to this Category) **Fee:** $356.25 **Benefit:** 75% = $267.20
Fee 49866	Excision of intermetatarsal or digital neuroma, including any of the following (if performed): (a) release of metatarsal or digital ligament; (b) excision of bursae; (c) neurolysis; other than a service associated with a service to which item 30023 applies—one web space (H) (Anaes.) (Assist.) **Fee:** $329.70 **Benefit:** 75% = $247.30

Fee 49878	Talipes equinovarus, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation—each attendance (Anaes.) **Fee:** $61.85 **Benefit:** 75% = $46.40 85% = $52.60
Fee 49881	Complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of interphalangeal or metatarsophalangeal joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) skin closure, by any local method; other than a service associated with a service to which item 30023 applies—each incision (H) (Anaes.) (Assist.) **Fee:** $240.85 **Benefit:** 75% = $180.65
Fee 49887	Revision of complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of interphalangeal or metatarsophalangeal joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) skin closure, by any method; other than a service associated with a service to which item 30023 or 49881 applies—each incision (H) (Anaes.) (Assist.) **Fee:** $325.25 **Benefit:** 75% = $243.95
	OTHER JOINTS
Fee 50112	Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.) **Fee:** $395.45 **Benefit:** 75% = $296.60
Fee 50115	Manipulation of one or more joints, excluding spine, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)

	Fee: $156.65 **Benefit:** 75% = $117.50
	Arthrodesis of joint of hindfoot, by any method, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; —one joint (H) (Anaes.) (Assist.)
Fee 50118	(See para TN.8.200 of explanatory notes to this Category) **Fee:** $858.15 **Benefit:** 75% = $643.65
Fee 50130	Joint or joints, application of external fixator to, other than for treatment of fractures (H) (Anaes.) (Assist.) **Fee:** $342.05 **Benefit:** 75% = $256.55
	MALIGNANT DISEASE
Fee 50200	Core needle biopsy of aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare (Anaes.) (See para TN.8.209 of explanatory notes to this Category) **Fee:** $206.10 **Benefit:** 75% = $154.60 85% = $175.20
Fee 50201	Incisional biopsy of aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare (Anaes.) (Assist.) (See para TN.8.209 of explanatory notes to this Category) **Fee:** $360.85 **Benefit:** 75% = $270.65 85% = $306.75
Fee 50203	Intralesional or marginal excision of bone or soft tissue tumour (Anaes.) (Assist.) (See para TN.8.209, TN.8.171 of explanatory notes to this Category) **Fee:** $453.70 **Benefit:** 75% = $340.30 85% = $385.65
	Intralesional or marginal excision of bone tumour, with at least one of the following: (a) autograft; (b) allograft; (c) cementation (H) (Anaes.) (Assist.)
Fee 50206	(See para TN.8.209, TN.8.171 of explanatory notes to this Category) **Fee:** $670.25 **Benefit:** 75% = $502.70
	Intralesional or marginal excision of bone tumour, with at least 2 of the following: (a) autograft;
Fee 50209	(b) allograft;

	(c) cementation (H) (Anaes.) (Assist.) (See para TN.8.209, TN.8.171 of explanatory notes to this Category) **Fee:** $825.00 **Benefit:** 75% = $618.75
Fee 50212	Wide excision of malignant or aggressive bone or soft tissue tumour (or both), affecting a limb, trunk or scapula (H) (Anaes.) (Assist.) (See para TN.8.173, TN.8.174 of explanatory notes to this Category) **Fee:** $1,804.45 **Benefit:** 75% = $1353.35
Fee 50215	Wide excision of malignant or aggressive bone or soft tissue tumour (or both), with intercalary reconstruction of bone by prosthesis, allograft or autograft (H) (Anaes.) (Assist.) (See para TN.8.173, TN.8.175 of explanatory notes to this Category) **Fee:** $2,268.45 **Benefit:** 75% = $1701.35
Fee 50218	Wide excision of malignant or aggressive bone or soft tissue tumour (or both), with reconstruction, replacement or arthrodesis of adjacent joint, by prosthesis, allograft or autograft (H) (Anaes.) (Assist.) (See para TN.8.173, TN.8.175 of explanatory notes to this Category) **Fee:** $2,990.30 **Benefit:** 75% = $2242.75
Fee 50221	Wide excision of malignant or aggressive bone or soft tissue tumour (or both) of pelvis, sacrum or spine, without reconstruction (H) (Anaes.) (Assist.) (See para TN.8.173, TN.8.175 of explanatory notes to this Category) **Fee:** $2,783.90 **Benefit:** 75% = $2087.95
Fee 50224	Wide excision of malignant or aggressive bone or soft tissue tumour (or both) of pelvis, sacrum or spine, with reconstruction of bone defect, or one or more joints, by any technique (Anaes.) (Assist.) (See para TN.8.173, TN.8.175 of explanatory notes to this Category) **Fee:** $3,093.30 **Benefit:** 75% = $2320.00 85% = $3000.10
Fee 50233	Treatment of malignant or aggressive bone or soft tissue tumour (or both) by hindquarter or forequarter amputation (H) (Anaes.) (Assist.) (See para TN.8.176 of explanatory notes to this Category) **Fee:** $2,371.55 **Benefit:** 75% = $1778.70
Fee 50236	Treatment of malignant or aggressive bone or soft tissue tumour (or both), by hip disarticulation, shoulder disarticulation or amputation through the proximal one third of the femur (H) (Anaes.) (Assist.) (See para TN.8.176 of explanatory notes to this Category) **Fee:** $1,856.00 **Benefit:** 75% = $1392.00
Fee 50239	Treatment of malignant or aggressive bone or soft tissue tumour (or both), by amputation, other than a service associated with a service to which item 50233 or 50236 applies (H) (Anaes.) (Assist.) (See para TN.8.176 of explanatory notes to this Category) **Fee:** $1,237.20 **Benefit:** 75% = $927.90
Fee 50242	Revision of endoprosthetic replacement, if item 50218 or 50224, or an item that describes a service substantially similar to either of those items, applied to the initial procedure: (a) including any of the following:

	(i) rebushing; (ii) patella resurfacing; (iii) polyethylene exchange or similar; and (b) excluding removal of prosthetic from bone (H) (Anaes.) (Assist.) **Fee:** $928.00 **Benefit:** 75% = $696.00
	LIMB LENGTHENING AND DEFORMITY CORRECTION
Fee 50245	Revision of reconstructive procedure, if item 50215, 50218 or 50224, or an item that describes a service substantially similar to any of those items, applied to the initial procedure, by any technique or combination of techniques (H) (Anaes.) (Assist.) **Fee:** $2,784.10 **Benefit:** 75% = $2088.10
Fee 50300	Gradual correction of joint deformity, with application of external fixator (H) (Anaes.) (Assist.) (See para TN.8.193 of explanatory notes to this Category) **Fee:** $1,267.90 **Benefit:** 75% = $950.95
Fee 50303	Limb lengthening, by gradual distraction, with application of external fixator or intra-medullary device (H) (Anaes.) (Assist.) (See para TN.8.193 of explanatory notes to this Category) **Fee:** $1,731.10 **Benefit:** 75% = $1298.35
Fee 50306	Bipolar limb lengthening: (a) with application of external fixator or intra-medullary device; and (b) by any of the following: (i) gradual distraction; (ii) bone transport; (iii) fixator extension, to correct for an adjacent joint deformity (H) (Anaes.) (Assist.) (See para TN.8.193 of explanatory notes to this Category) **Fee:** $2,702.90 **Benefit:** 75% = $2027.20
Fee 50309	Ring fixator or similar device, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia, other than a service to which item 50303 or 50306 applies (H) (Anaes.) (Assist.) (See para TN.8.193 of explanatory notes to this Category) **Fee:** $334.15 **Benefit:** 75% = $250.65
Fee 50310	Major adjustment of ring fixator or similar device, other than a service associated with a service to which item 50303, 50306, or 50309 applies (See para TN.8.192 of explanatory notes to this Category) **Fee:** $47.80 **Benefit:** 75% = $35.85 85% = $40.65

Fee 50312	Synovectomy or debridement, and microfracture, of ankle joint for osteochondral large defect greater than 1.5cm^2, by arthroscopic or open means, including any of the following (if performed): (a) capsulotomy; (b) debridement or release of ligament; (c) debridement or release of tendon; other than a service associated with a service to which any of the following apply: (d) item 49703; (e) another item in this Schedule if the service described in the other item is for the purpose of performing an arthroscopic procedure of the ankle (H) (Anaes.) (Assist.) **Fee:** $823.85 **Benefit:** 75% = $617.90
Fee 50321	Release of soft tissue of talipes equinovarus, by open means (H) (Anaes.) (Assist.) **Fee:** $1,017.25 **Benefit:** 75% = $762.95
Fee 50324	Revision of release of soft tissue of talipes equinovarus, by open means (H) (Anaes.) (Assist.) **Fee:** $1,450.30 **Benefit:** 75% = $1087.75
Fee 50330	Post-operative manipulation, and change of plaster, of vertical, congenital talipes equinovarus or talus, other than a service to which item 50321 or 50324 applies (H) (Anaes.) **Fee:** $250.45 **Benefit:** 75% = $187.85
Fee 50333	Excision of tarsal coalition, with interposition of muscle, fat graft or similar graft, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) excision of osteophytes; —one coalition (H) (Anaes.) (Assist.) **Fee:** $675.50 **Benefit:** 75% = $506.65
Fee 50335	Treatment of vertical, congenital talus, by percutaneous or open stabilisation of talonavicular joint and Achilles' tenotomy (H) (Anaes.) (Assist.) **Fee:** $675.50 **Benefit:** 75% = $506.65
Fee 50336	Talus, vertical, congenital, combined anterior and posterior reconstruction (H) (Anaes.) (Assist.) **Fee:** $1,009.85 **Benefit:** 75% = $757.40
Fee 50339	Tibialis anterior or tibialis posterior tendon transfer (split or whole) (H) (Anaes.) (Assist.) **Fee:** $646.70 **Benefit:** 75% = $485.05

Fee 50345	Hyperextension deformity of toe, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (H) (Anaes.) (Assist.) **Fee:** $379.65 **Benefit:** 75% = $284.75
Fee 50348	Knee, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia (H) (Anaes.) **Fee:** $250.45 **Benefit:** 75% = $187.85
Fee 50351	Treatment of developmental dislocation of hip, by open reduction, including application of hip spica (H) (Anaes.) (Assist.) **Fee:** $1,749.35 **Benefit:** 75% = $1312.05
Fee 50352	Treatment of developmental dysplasia of hip, including supervision of initial application of splint, harness or cast, other than a service to which another item in this Group applies (Anaes.) **Fee:** $61.85 **Benefit:** 75% = $46.40 85% = $52.60
Fee 50354	Resection and fixation of congenital pseudarthrosis of tibia (Anaes.) (Assist.) **Fee:** $1,434.85 **Benefit:** 75% = $1076.15 85% = $1341.65
Fee 50357	Transfer of tendon of rectus femoris or medial or lateral hamstring (H) (Anaes.) (Assist.) **Fee:** $615.00 **Benefit:** 75% = $461.25
Fee 50360	Combined medial and lateral hamstring tendon transfer (H) (Anaes.) (Assist.) **Fee:** $713.70 **Benefit:** 75% = $535.30
Fee 50369	Unilateral posterior release of knee contracture, with multiple tendon lengthening or tenotomies, including release of joint capsule (if performed), other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of knee replacement (H) (Anaes.) (Assist.) **Fee:** $713.70 **Benefit:** 75% = $535.30
Fee 50372	Bilateral posterior release of knee contracture, with multiple tendon lengthening or tenotomies, including release of joint capsule (if performed), other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of knee replacement (H) (Anaes.) (Assist.) **Fee:** $1,252.75 **Benefit:** 75% = $939.60
Fee 50375	Unilateral medial release of hip contracture, with lengthening or division of the adductors and psoas, including division of obturator nerve (if performed) (H) (Anaes.) (Assist.) **Fee:** $546.60 **Benefit:** 75% = $409.95
Fee 50378	Bilateral medial release of hip contracture, with lengthening or division of adductors and psoas, including division of obturator nerve (if performed) (H) (Anaes.) (Assist.) **Fee:** $956.65 **Benefit:** 75% = $717.50
Fee 50381	Unilateral anterior release of hip contracture, with lengthening or division of hip flexors and psoas, including division of joint capsule (if performed) (H) (Anaes.) (Assist.) **Fee:** $713.70 **Benefit:** 75% = $535.30

Fee 50384	Bilateral anterior release of hip contracture, with lengthening or division of hip flexors and psoas, including division of joint capsule (if performed) (H) (Anaes.) (Assist.) **Fee:** $1,252.75 **Benefit:** 75% = $939.60
Fee 50390	Application of cast under general anaesthesia, for patient with perthes, cerebral palsy, or other neuromuscular conditions, affecting hips or knees (H) (Anaes.) **Fee:** $250.45 **Benefit:** 75% = $187.85
Fee 50393	Acetabular shelf procedure, other than a service associated with a service to which another item of this Schedule applies if the service in the other item is for the purpose of performing arthroplasty on the hip (H) (Anaes.) (Assist.) **Fee:** $926.20 **Benefit:** 75% = $694.65
Fee 50394	Multiple peri-acetabular osteotomy, including internal fixation (if performed) (H) (Anaes.) (Assist.) **Fee:** $3,041.85 **Benefit:** 75% = $2281.40
Fee 50396	Amputation of congenital abnormalities or duplication of digits of the hand or foot, including any of the following (if performed): (a) splitting of phalanx or phalanges; (b) ligament reconstruction; (c) joint reconstruction (H) (Anaes.) (Assist.) **Fee:** $508.85 **Benefit:** 75% = $381.65
Fee 50399	Forearm, radial aplasia or dysplasia (radial club hand), centralisation or radialisation of (H) (Anaes.) (Assist.) **Fee:** $1,009.85 **Benefit:** 75% = $757.40
Fee 50411	Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.) **Fee:** $1,434.85 **Benefit:** 75% = $1076.15 85% = $1341.65
Fee 50414	Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.) **Fee:** $1,935.95 **Benefit:** 75% = $1452.00 85% = $1842.75
Fee 50417	Lower limb deficiency, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Anaes.) (Assist.) **Fee:** $1,434.85 **Benefit:** 75% = $1076.15 85% = $1341.65
Fee 50420	Patella, congenital dislocation of, reconstruction of the quadriceps (H) (Anaes.) (Assist.) **Fee:** $1,184.35 **Benefit:** 75% = $888.30
Fee 50423	Tibia, fibula or both, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.) **Fee:** $1,093.25 **Benefit:** 75% = $819.95 85% = $1000.05

Fee 50426	Removal of one or more lesions from bone, for osteochondroma occurring solitary or in association with hereditary multiple exotoses, with histological examination—one approach (H) (Anaes.) (Assist.) **Fee:** $508.85 **Benefit:** 75% = $381.65
Fee 50428	Percutaneous drilling of osteochondritis dessicans or other osteochondral lesion, for a patient: (a) with open growth plates; or (b) less than 18 years of age (H) (Anaes.) (Assist.) **Fee:** $849.45 **Benefit:** 75% = $637.10
	SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY
Fee 50450	Unilateral single event multilevel surgery, for a patient less than 18 years of age with hemiplegic cerebral palsy, comprising 3 or more of the following: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; (b) correction of muscle imbalance by transfer of a tendon or tendons; (c) correction of femoral torsion by rotational osteotomy of the femur; (d) correction of tibial torsion by rotational osteotomy of the tibia; (e) correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis with synovectomy if performed, or os calcis lengthening; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,343.80 **Benefit:** 75% = $1007.85
Fee 50451	Unilateral single event multilevel surgery, for a patient less than 18 years of age with hemiplegic cerebral palsy, comprising 3 or more of the following: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; (b) correction of muscle imbalance by transfer of a tendon or tendons; (c) correction of femoral torsion by rotational osteotomy of the femur; (d) correction of tibial torsion by rotational osteotomy of the tibia; (e) correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis with synovectomy if performed, or os calcis lengthening; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,343.80 **Benefit:** 75% = $1007.85

	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)
Fee 50455	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,521.75 **Benefit:** 75% = $1141.35
	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)
Fee 50456	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,521.75 **Benefit:** 75% = $1141.35
	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of torsional abnormality of the femur by rotational osteotomy and internal fixation; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)
Fee 50460	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,272.00 **Benefit:** 75% = $1704.00
	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of torsional abnormality of the femur by rotational osteotomy and internal fixation; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)
Fee 50461	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,272.00 **Benefit:** 75% = $1704.00

	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)
Fee 50465	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,200.05 **Benefit:** 75% = $2400.05
	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)
Fee 50466	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,200.05 **Benefit:** 75% = $2400.05
	Bilateral single event multilevel surgery, for a patient less than 18 years of age with cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and (e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)
Fee 50470	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,058.45 **Benefit:** 75% = $3043.85

	Bilateral single event multilevel surgery, for a patient less than 18 years of age with cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and (e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)
Fee 50471	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,058.45 **Benefit:** 75% = $3043.85
	Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait, including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; and (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; and (e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)
Fee 50475	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,683.05 **Benefit:** 75% = $3512.30
	Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; and (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; and
Fee 50476	

	(e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,683.05 **Benefit:** 75% = $3512.30
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS
Fee 50508	Treatment of fracture of distal end of radius or ulna (or both), by closed reduction, for a patient with open growth plates (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $432.85 **Benefit:** 75% = $324.65 85% = $367.95
Fee 50512	Treatment of fracture of distal end of radius or ulna (or both), by open or closed reduction, with internal fixation, for a patient with open growth plates (H) (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $577.55 **Benefit:** 75% = $433.20
Fee 50524	Radius or ulna, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction (H) (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $447.45 **Benefit:** 75% = $335.60
Fee 50528	Radius or ulna, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $721.75 **Benefit:** 75% = $541.35
Fee 50532	Treatment of fracture of shafts of radius or ulna (or both), by closed reduction, for a patient with open growth plate (H) (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $627.95 **Benefit:** 75% = $471.00
Fee 50536	Treatment of fracture of shafts of radius or ulna (or both), by open or closed reduction, with internal fixation, for a patient with open growth plate (H) (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $837.25 **Benefit:** 75% = $627.95
Fee 50540	Olecranon, with open growth plate, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $577.55 **Benefit:** 75% = $433.20
Fee 50544	Radius, with open growth plate, treatment of fracture of head or neck of, by closed reduction of (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $288.70 **Benefit:** 75% = $216.55 85% = $245.40

	Radius, with open growth plate, treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)
Fee 50548	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $577.55 **Benefit:** 75% = $433.20
	Humerus, proximal, with open growth plate, treatment of fracture of, by closed reduction (H) (Anaes.)
Fee 50552	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $498.05 **Benefit:** 75% = $373.55
	Treatment of fracture of proximal humerus, by open or closed reduction, with internal fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)
Fee 50556	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $663.95 **Benefit:** 75% = $498.00
	Humerus, shaft of, with open growth plate, treatment of fracture of, by closed reduction (H) (Anaes.)
Fee 50560	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $519.60 **Benefit:** 75% = $389.70
	Treatment of fracture of shaft of humerus, by open or closed reduction, with internal or external fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)
Fee 50564	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $692.90 **Benefit:** 75% = $519.70
	Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction (H) (Anaes.)
Fee 50568	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $606.30 **Benefit:** 75% = $454.75
	Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)
Fee 50572	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $808.40 **Benefit:** 75% = $606.30
	Treatment of fracture of femur, by closed reduction or traction, including application of hip spica (if performed), for a patient with open growth plate (Anaes.) (Assist.)
Fee 50576	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $663.95 **Benefit:** 75% = $498.00 85% = $570.75
	Tibia, with open growth plate, plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)
Fee 50580	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $692.90 **Benefit:** 75% = $519.70
	Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)
Fee 50584	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $663.95 **Benefit:** 75% = $498.00
Fee 50588	Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category)

	Fee: $866.00 **Benefit:** 75% = $649.50
Fee 50592	Treatment of fracture of shaft of femur, by open or closed reduction, with internal or external fixation, for a patient with open growth plate (H) (Anaes.) (Assist.) **Fee:** $1,051.70 **Benefit:** 75% = $788.80
Fee 50596	Treatment of fracture of shaft of tibia, by open or closed reduction, including casting, for a patient with open growth plate (H) (Anaes.) (Assist.) **Fee:** $328.75 **Benefit:** 75% = $246.60
	SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS
Fee 50600	Scoliosis or kyphosis, in a child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $476.10 **Benefit:** 75% = $357.10
Fee 50604	Scoliosis or kyphosis, in a child or adolescent, spinal fusion for (without instrumentation) (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,020.65 **Benefit:** 75% = $1515.50
Fee 50608	Scoliosis or kyphosis, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,753.30 **Benefit:** 75% = $2815.00
Fee 50612	Scoliosis or kyphosis, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $5,338.70 **Benefit:** 75% = $4004.05
Fee 50616	Scoliosis, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $678.30 **Benefit:** 75% = $508.75
Fee 50620	Scoliosis, in a child or adolescent, revision of failed scoliosis surgery, involving more than one of osteotomy, fusion, removal of instrumentation or instrumentation, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,753.30 **Benefit:** 75% = $2815.00
Fee 50624	Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,753.30 **Benefit:** 75% = $2815.00
Fee 50628	Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar)—more than 4 levels (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,636.35 **Benefit:** 75% = $3477.30

	Scoliosis or kyphosis, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)
Fee 50632	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,897.60 **Benefit:** 75% = $2923.20
	Scoliosis, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)
Fee 50636	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,330.65 **Benefit:** 75% = $3248.00
	Scoliosis, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)
Fee 50640	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,393.95 **Benefit:** 75% = $1795.50
	Spine, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (H) (Anaes.) (Assist.)
Fee 50644	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,309.75 **Benefit:** 75% = $1732.35
	TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS
	Treatment of hip dysplasia or dislocation, for a patient under the age of 18 years, by examination or closed reduction (or both), with or without arthrography of the hip under anaesthesia, and with application or reapplication of a hip spica (H) (Anaes.) (Assist.)
Fee 50654	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $543.90 **Benefit:** 75% = $407.95

	Group T8. Surgical Operations
	Subgroup 16. Radiofrequency And Microwave Tissue Ablation
	Unresectable primary malignant tumour of the liver, destruction of, by percutaneous ablation (including any associated imaging services), other than a service associated with a service to which item 30419 or 50952 applies (Anaes.)
Fee 50950	**Fee:** $894.90 **Benefit:** 75% = $671.20 85% = $801.70
	Unresectable primary malignant tumour of the liver, destruction of, by open or laparoscopic ablation (including any associated imaging services), if a multi-disciplinary team has assessed that percutaneous ablation cannot be performed or is not practical because of one or more of the following clinical circumstances: (a) percutaneous access cannot be achieved;
Fee 50952	(b) vital organs or tissues are at risk of damage from the percutaneous ablation procedure;

	(c) resection of one part of the liver is possible, however there is at least one primary liver tumour in an unresectable portion of the liver that is suitable for ablation; other than a service associated with a service to which item 30419 or 50950 applies (Anaes.) (See para TN.8.120 of explanatory notes to this Category) **Fee:** $894.90 **Benefit:** 75% = $671.20 85% = $801.70

	Group T8. Surgical Operations
	Subgroup 17. Spinal Surgery
Fee 51011	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, one motion segment, not being a service associated with a service to which item 51012, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $1,572.20 **Benefit:** 75% = $1179.15
Fee 51012	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 2 motion segments, not being a service associated with a service to which item 51011, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $2,096.00 **Benefit:** 75% = $1572.00
Fee 51013	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 3 motion segments, not being a service associated with a service to which item 51011, 51012, 51014 or 51015 applies (H) (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $2,620.10 **Benefit:** 75% = $1965.10
Fee 51014	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51015 applies (H) (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $3,144.10 **Benefit:** 75% = $2358.10
Fee 51015	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, more than 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51014 applies (H) (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $3,668.10 **Benefit:** 75% = $2751.10
Fee 51020	Simple fixation of part of one vertebra (not motion segment) including pars interarticularis, spinous process or pedicle, or simple interspinous wiring between 2 adjacent vertebral levels, not being a service associated with: (a) interspinous dynamic stabilisation devices; or (b) a service to which item 51021, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.)

	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $838.35 **Benefit:** 75% = $628.80
Fee 51021	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, one motion segment, not being a service associated with a service to which item 51020, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $1,403.25 **Benefit:** 75% = $1052.45
Fee 51022	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 2 motion segments, not being a service associated with a service to which item 51020, 51021, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $1,745.50 **Benefit:** 75% = $1309.15
Fee 51023	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 3 or 4 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51024, 51025 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $2,077.25 **Benefit:** 75% = $1557.95
Fee 51024	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 5 or 6 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51025 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $2,398.10 **Benefit:** 75% = $1798.60
Fee 51025	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 7 to 12 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $2,802.90 **Benefit:** 75% = $2102.20
Fee 51026	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, more than 12 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51025 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $3,068.75 **Benefit:** 75% = $2301.60
Fee 51031	Spine, posterior and/or posterolateral bone graft to, one motion segment, not being a service associated with a service to which item 51032, 51033, 51034, 51035 or 51036 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $1,031.10 **Benefit:** 75% = $773.35
Fee 51032	Spine, posterior and/or posterolateral bone graft to, 2 motion segments, not being a service associated with a service to which item 51031, 51033, 51034, 51035 or 51036 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $1,237.35 **Benefit:** 75% = $928.05
Fee 51033	Spine, posterior and/or posterolateral bone graft to, 3 motion segments, not being a service associated with a service to which item 51031, 51032, 51034, 51035 or 51036 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category)

	Fee: $1,443.60 **Benefit:** 75% = $1082.70
Fee 51034	Spine, posterior and/or posterolateral bone graft to, 4 to 7 motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51035 or 51036 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $1,546.65 **Benefit:** 75% = $1160.00
Fee 51035	Spine, posterior and/or posterolateral bone graft to, 8 to 11 motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51034 or 51036 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $1,649.80 **Benefit:** 75% = $1237.35
Fee 51036	Spine, posterior and/or posterolateral bone graft to, 12 or more motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51034 or 51035 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $1,752.90 **Benefit:** 75% = $1314.70
Fee 51041	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), one motion segment, not being a service associated with a service to which item 51042, 51043, 51044 or 51045 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.145 of explanatory notes to this Category) **Fee:** $1,185.75 **Benefit:** 75% = $889.35
Fee 51042	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 2 motion segments, not being a service associated with a service to which item 51041, 51043, 51044 or 51045 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.145 of explanatory notes to this Category) **Fee:** $1,660.15 **Benefit:** 75% = $1245.15
Fee 51043	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 3 motion segments, not being a service associated with a service to which item 51041, 51042, 51044 or 51045 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.145 of explanatory notes to this Category) **Fee:** $2,075.20 **Benefit:** 75% = $1556.40
Fee 51044	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 4 motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51045 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.145 of explanatory notes to this Category) **Fee:** $2,253.05 **Benefit:** 75% = $1689.80
Fee 51045	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 5 or more motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51044 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.145 of explanatory notes to this Category) **Fee:** $2,371.60 **Benefit:** 75% = $1778.70
Fee 51051	Pedicle subtraction osteotomy, one vertebra, not being a service associated with a service to which item 51052, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,026.15 **Benefit:** 75% = $1519.65

	Pedicle subtraction osteotomy, 2 vertebrae, not being a service associated with a service to which item 51051, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)
Fee 51052	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,464.30 **Benefit:** 75% = $1848.25
	Vertebral column resection osteotomy performed through single posterior approach, one vertebra, not being a service associated with a service to which item 51051, 51052, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)
Fee 51053	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,803.75 **Benefit:** 75% = $2102.85
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), one vertebra, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)
Fee 51054	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $1,494.95 **Benefit:** 75% = $1121.25
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 2 vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)
Fee 51055	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,242.45 **Benefit:** 75% = $1681.85
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 3 or more vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51057, 51058 or 51059 applies (Anaes.) (Assist.)
Fee 51056	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,616.15 **Benefit:** 75% = $1962.15
	Vertebral body, en bloc excision of (complete spondylectomy), one vertebra, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51058 or 51059 applies (Anaes.) (Assist.)
Fee 51057	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,628.55 **Benefit:** 75% = $1971.45

	Vertebral body, en bloc excision of (complete spondylectomy), 2 vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51059 applies (Anaes.) (Assist.)
Fee 51058	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,957.60 **Benefit:** 75% = $2218.20
	Vertebral body, en bloc excision of (complete spondylectomy), 3 or more vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51058 applies (Anaes.) (Assist.)
Fee 51059	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $3,614.30 **Benefit:** 75% = $2710.75
	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.)
Fee 51061	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $3,104.60 **Benefit:** 75% = $2328.45
	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.)
Fee 51062	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $4,024.25 **Benefit:** 75% = $3018.20
	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.)
Fee 51063	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $4,874.10 **Benefit:** 75% = $3655.60
	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.)
Fee 51064	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $5,424.50 **Benefit:** 75% = $4068.40
	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.)
Fee 51065	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $5,999.50 **Benefit:** 75% = $4499.65

	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.)
Fee 51066	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $6,316.75 **Benefit:** 75% = $4737.60
	Removal of intradural lesion, or primary extradural tumour or lesion, where the pathology is confirmed by histology - not including removal of synovial or juxtafacet cyst and not being a service associated with a service to which item 51072 or 51073 applies (H) (Anaes.) (Assist.)
Fee 51071	(See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,738.05 **Benefit:** 75% = $2053.55
	Craniocervical junction lesion, transoral approach for, not being a service associated with a service to which item 51071 or 51073 applies (Anaes.) (Assist.)
Fee 51072	(See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,847.60 **Benefit:** 75% = $2135.70
	Removal of intramedullary tumour or arteriovenous malformation, not being a service associated with a service to which item 51071 or 51072 applies (Anaes.) (Assist.)
Fee 51073	(See para TN.8.141 of explanatory notes to this Category) **Fee:** $3,614.30 **Benefit:** 75% = $2710.75
	Thoracoplasty in combination with thoracic scoliosis correction—3 or more ribs (Anaes.) (Assist.)
Fee 51102	(See para TN.8.141 of explanatory notes to this Category) **Fee:** $1,296.15 **Benefit:** 75% = $972.15
	Odontoid screw fixation (Anaes.) (Assist.)
Fee 51103	(See para TN.8.141, TN.8.148 of explanatory notes to this Category) **Fee:** $2,277.80 **Benefit:** 75% = $1708.35
	Spine, treatment of fracture, dislocation or fracture dislocation, with immobilisation by calipers or halo, not including application of skull tongs or calipers as part of operative positioning (Anaes.)
Fee 51110	(See para TN.8.141 of explanatory notes to this Category) **Fee:** $825.00 **Benefit:** 75% = $618.75 85% = $731.80
	Skull calipers or halo, insertion of, as an independent procedure (Anaes.)
Fee 51111	(See para TN.8.141 of explanatory notes to this Category) **Fee:** $350.65 **Benefit:** 75% = $263.00
	Plaster jacket, application of, as an independent procedure (Anaes.)
Fee 51112	(See para TN.8.141 of explanatory notes to this Category) **Fee:** $237.10 **Benefit:** 75% = $177.85 85% = $201.55
	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.)
Fee 51113	(See para TN.8.141 of explanatory notes to this Category) **Fee:** $262.95 **Benefit:** 75% = $197.25
	Halo thoracic orthosis—application of both halo and thoracic jacket (Anaes.)
Fee 51114	(See para TN.8.141 of explanatory notes to this Category) **Fee:** $464.15 **Benefit:** 75% = $348.15

	Halo femoral traction, as an independent procedure (Anaes.) (See para TN.8.141 of explanatory notes to this Category)
Fee 51115	**Fee:** $464.15 **Benefit:** 75% = $348.15 85% = $394.55
	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.) (See para TN.8.141 of explanatory notes to this Category)
Fee 51120	**Fee:** $257.90 **Benefit:** 75% = $193.45
	Lumbar artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes: (a) for a patient who: (i) has not had prior spinal fusion surgery at the same lumbar level; and (ii) does not have vertebral osteoporosis; and (iii) has failed conservative therapy; and (b) not being a service associated with a service to which item 51011, 51012, 51013, 51014 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category)
Fee 51130	**Fee:** $1,964.45 **Benefit:** 75% = $1473.35
	Cervical artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes, for a patient who: (a) has not had prior spinal surgery at the same cervical level; and (b) is skeletally mature; and (c) has symptomatic degenerative disc disease with radiculopathy; and (d) does not have vertebral osteoporosis; and (e) has failed conservative therapy (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category)
Fee 51131	**Fee:** $1,185.75 **Benefit:** 75% = $889.35
	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation up to 3 motion segments, not being a service associated with a service to which item 51141 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category)
Fee 51140	**Fee:** $484.60 **Benefit:** 75% = $363.45
	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation more than 3 motion segments, not being a service associated with a service to which item 51140 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category)
Fee 51141	**Fee:** $896.50 **Benefit:** 75% = $672.40

Fee 51145	Wound debridement or excision for post operative infection or haematoma following spinal surgery (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $484.60 **Benefit:** 75% = $363.45
Fee 51150	Coccyx, excision of (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $487.85 **Benefit:** 75% = $365.90
Fee 51160	Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service to which item 51165 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.149 of explanatory notes to this Category) **Fee:** $1,259.50 **Benefit:** 75% = $944.65
Fee 51165	Anterior exposure of thoracic or lumbar spine, more than one motion segment, not being a service to which item 51160 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.149 of explanatory notes to this Category) **Fee:** $1,588.10 **Benefit:** 75% = $1191.10
Fee 51170	Syringomyelia or hydromyelia, craniotomy for, with or without duraplasty, intradural dissection, plugging of obex or local cerebrospinal fluid shunt (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,392.65 **Benefit:** 75% = $1794.50
Fee 51171	Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid shunt (for example, syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal shunt) (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $1,004.75 **Benefit:** 75% = $753.60

	Group T8. Surgical Operations
	Subgroup 18. Myringoplasty and Tympanomastoid Procedures
Fee 41527	Myringoplasty, by transcanal approach, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $643.55 **Benefit:** 75% = $482.70
Fee 41530	Myringoplasty, post-aural or endaural approach, with or without mastoid inspection, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) **Fee:** $1,048.50 **Benefit:** 75% = $786.40
Fee 41533	Atticotomy without reconstruction of the bony defect, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $1,253.25 **Benefit:** 75% = $939.95
Fee 41536	Atticotomy with reconstruction of the bony defect, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)

	Fee: $1,403.80 **Benefit:** 75% = $1052.85
Fee 41545	Mastoidectomy (cortical), other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 41551	Mastoidectomy, intact wall technique, with myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $1,744.80 **Benefit:** 75% = $1308.60
Fee 41554	Mastoidectomy, intact wall technique, with myringoplasty and ossicular chain reconstruction, other than a service associated with a service to which item 41603 or another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $2,055.70 **Benefit:** 75% = $1541.80
Fee 41557	Mastoidectomy (radical or modified radical), other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $1,193.70 **Benefit:** 75% = $895.30
Fee 41560	Mastoidectomy (radical or modified radical) and myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) **Fee:** $1,308.00 **Benefit:** 75% = $981.00
Fee 41563	Mastoidectomy (radical or modified radical), myringoplasty and ossicular chain reconstruction, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $1,619.15 **Benefit:** 75% = $1214.40
Fee 41564	Mastoidectomy (radical or modified radical), obliteration of the mastoid cavity, blind sac closure of external auditory canal and obliteration of eustachian tube, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $2,093.90 **Benefit:** 75% = $1570.45
Fee 41566	Revision of mastoidectomy (radical, modified radical or intact wall), including myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $1,193.70 **Benefit:** 75% = $895.30
Fee 41629	Middle ear, exploration of, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $570.95 **Benefit:** 75% = $428.25
Fee 41635	Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) **Fee:** $1,253.25 **Benefit:** 75% = $939.95
Fee 41638	Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty with ossicular chain reconstruction other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)

T8. SURGICAL OPERATIONS	18. MYRINGOPLASTY AND TYMPANOMASTOID PROCEDURES
	Fee: $1,564.35 **Benefit:** 75% = $1173.30

T8. SURGICAL OPERATIONS	19. FUNCTIONAL SINUS SURGERY
	Group T8. Surgical Operations
	Subgroup 19. Functional Sinus Surgery
Fee 41702 S	Functional sinus surgery of the ostiomeatal unit, including ethmoid, unilateral, other than a service associated with a service to which item 41662, 41698, 41703, 41705, 41710 or 41764 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $747.35 **Benefit:** 75% = $560.55
Fee 41703 S	Functional sinus surgery, complete dissection of all 5 sinuses and creation of single sinus cavity, unilateral, other than a service associated with a service to which item 41662, 41698, 41702, 41705, 41710, 41734, 41737, 41752 or 41764 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $1,104.90 **Benefit:** 75% = $828.70
Fee 41705 S	Functional sinus surgery, complete dissection of all 5 sinuses to create a single sinus cavity, with extended drilling of frontal sinuses, unilateral, other than a service associated with a service to which item 41662, 41698, 41702, 41703, 41710, 41734, 41737, 41752 or 41764 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $1,797.75 **Benefit:** 75% = $1348.35

T8. SURGICAL OPERATIONS	20. SINUS PROCEDURES
	Group T8. Surgical Operations
	Subgroup 20. Sinus Procedures
Fee 41710	Antrostomy by any approach, other than a service associated with a service to which item 41702, 41703, 41705 or 41698 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $387.50 **Benefit:** 75% = $290.65
Fee 41734	Endoscopic Lothrop procedure or radical external frontal sinusotomy with osteoplastic flap, unilateral, other than a service associated with a service to which item 41698, 41703, 41705 or 41764 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $1,110.60 **Benefit:** 75% = $832.95
Fee 41737	Frontal sinus, unilateral, intranasal operation on, including complete dissection of frontal recess and exposure of frontal sinus ostium (excludes simple probing, dilatation or irrigation of frontal sinus), other than a service associated with a service to which item 41698, 41703, 41705 or 41764 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $529.30 **Benefit:** 75% = $397.00
Fee 41752	Sphenoidal sinus, unilateral, intranasal operation on, other than a service associated with a service to which item 41703 or 41705 applies on the same side (H) (Anaes.) (Assist.) **Fee:** $323.85 **Benefit:** 75% = $242.90

T8. SURGICAL OPERATIONS	21. AIRWAY PROCEDURES
	Group T8. Surgical Operations
	Subgroup 21. Airway Procedures
Fee 41671	Septal surgery, including septoplasty, septal reconstruction, septectomy, closure of septal perforation or other modifications of the septum, not including cauterisation, by any approach, other than a service associated with a service to which item 41689, 41692 or 41693 applies (H) (Anaes.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $574.45 **Benefit:** 75% = $430.85
Fee 41689	Turbinate reduction, partial or total, unilateral or bilateral, other than a service associated with a service to which item 41671, 41692 or 41693 applies (Anaes.) **Fee:** $224.30 **Benefit:** 75% = $168.25 85% = $190.70
Fee 41692	Turbinate, submucous resection with removal of bone, unilateral or bilateral, other than a service associated with a service to which item 41671, 41689 or 41693 applies (H) (Anaes.) **Fee:** $292.50 **Benefit:** 75% = $219.40
Fee 41693 S	Septal surgery with submucous resection of turbinates, unilateral or bilateral, other than a service associated with a service to which item 41671, 41689, 41692 or 41764 applies (H) (Anaes.) **Fee:** $840.10 **Benefit:** 75% = $630.10

T9. ASSISTANCE AT OPERATIONS	
	Group T9. Assistance At Operations
Amend **Fee** 51300	Assistance at any operation identified by the word "Assist." for which the fee does not exceed $611.50 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 $611.50 (See para TN.9.2, TN.9.1 of explanatory notes to this Category) **Fee:** $94.55 **Benefit:** 75% = $70.95 85% = $80.40
Amend 51303	Assistance at any operation identified by the word "Assist." for which the fee exceeds $611.50 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds $611.50 (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
Fee 51306	Assistance at a birth involving Caesarean section (See para TN.9.1 of explanatory notes to this Category) **Fee:** $136.55 **Benefit:** 75% = $102.45 85% = $116.10
51309	Assistance at a series or combination of operations that include “(Assist.)” and assistance at a birth involving Caesarean section (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)
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627 (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

T9. ASSISTANCE AT OPERATIONS	
Fee 51315	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779 (See para TN.9.1 of explanatory notes to this Category) **Fee:** $298.35 **Benefit:** 75% = $223.80 85% = $253.60
Fee 51318	Assistance at cataract and intraocular lens surgery where patient has: - total loss of vision, including no potential for central vision, in the fellow eye; or - previous significant surgical complication in the fellow eye; or - pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage (See para TN.9.5, TN.9.1 of explanatory notes to this Category) **Fee:** $196.90 **Benefit:** 75% = $147.70 85% = $167.40

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	1. HEAD
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 1. Head
Fee 20100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20102	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20104	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20124	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20140	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on eye, not being a service to which another item in this Group applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	**1. HEAD**
Fee 20142	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25 **Extended Medicare Safety Net Cap:** $86.80
Fee 20143	INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20144	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20145	INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20146	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20147	INITIATION OF MANAGEMENT OF ANAESTHESIA for squint repair (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20148	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20160	Initiation of the management of anaesthesia for intranasal or accessory sinuses, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20162	Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal ablation (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20164	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20170	INITIATION OF MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20172	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20174	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units) **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05
Fee 20176	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units)

	Fee: $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20190	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on facial bones, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20192	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20210	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 20212	INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20214	INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units) **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05
Fee 20216	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units) **Fee:** $434.00 **Benefit:** 75% = $325.50 85% = $368.90
Fee 20220	INITIATION OF MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20222	INITIATION OF MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20225	INITIATION OF MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units) **Fee:** $260.40 **Benefit:** 75% = $195.30 85% = $221.35
Fee 20230	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the head or face (12 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $260.40 **Benefit:** 75% = $195.30 85% = $221.35

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 2. Neck
Fee 20300	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20305	INITIATION OF MANAGEMENT OF ANAESTHESIA for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 20320	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20321	INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20330	INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose and mouth) (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 20350	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major vessels of neck, not being a service to which another item in this Subgroup applies (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20352	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20355	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the neck (12 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $260.40 **Benefit:** 75% = $195.30 85% = $221.35

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 3. Thorax
Fee 20400	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 20401	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20402	Initiation of management of anaesthesia for reconstructive procedures on breast including implant reconstruction and exchange (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20403	Initiation of management of anaesthesia for axillary dissection or sentinel node biopsy (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20404	INITIATION OF MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20405	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breast using myocutaneous flaps (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 20406	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on breast with internal mammary node dissection (13 basic units) **Fee:** $282.10 **Benefit:** 75% = $211.60 85% = $239.80
Fee 20410	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20420	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20440	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the sternum (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	3. THORAX
Fee 20450	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on clavicle, scapula or sternum, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20452	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or sternum (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20470	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial rib resection, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20472	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20474	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic units) (See para TN.10.22 of explanatory notes to this Category) **Fee:** $282.10 **Benefit:** 75% = $211.60 85% = $239.80
Fee 20475	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior thorax (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	4. INTRATHORACIC
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 4. Intrathoracic
Fee 20500	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 20520	INITIATION OF MANAGEMENT OF ANAESTHESIA for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20522	INITIATION OF MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	4. INTRATHORACIC
	Fee: $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20524	INITIATION OF MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20526	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20528	INITIATION OF MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 20540	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this Subgroup applies (13 basic units) **Fee:** $282.10 **Benefit:** 75% = $211.60 85% = $239.80
Fee 20542	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 20546	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 20548	INITIATION OF MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea and bronchi (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 20560	Initiation of the management of anaesthesia for: (a) open procedures on the heart, pericardium or great vessels of the chest; or (b) percutaneous insertion of a valvular prosthesis (20 basic units) **Fee:** $434.00 **Benefit:** 75% = $325.50 85% = $368.90

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	5. SPINE AND SPINAL CORD
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 5. Spine And Spinal Cord

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	5. SPINE AND SPINAL CORD
Fee 20600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord, not being a service to which another item in this Subgroup applies (for myelography and discography see Items 21908 and 21914) (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20604	INITIATION OF MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the patient in the sitting position (13 basic units) **Fee:** $282.10 **Benefit:** 75% = $211.60 85% = $239.80
Fee 20620	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord, not being a service to which another item in this Subgroup applies (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20622	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic units) **Fee:** $282.10 **Benefit:** 75% = $211.60 85% = $239.80
Fee 20630	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures in lumbar region, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 20632	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20634	INITIATION OF MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20670	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord procedures (13 basic units) (See para TN.10.23 of explanatory notes to this Category) **Fee:** $282.10 **Benefit:** 75% = $211.60 85% = $239.80
Fee 20680	INITIATION OF MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in the operating theatre of a hospital (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 20690	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 6. Upper Abdomen
Fee 20700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 20702	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20703	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20704	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20706	Initiation of the management of anaesthesia for laparoscopic procedures in the upper abdomen, including laparoscopic cholecystectomy, not being a service to which another item in this Subgroup applies (7 basic units) (See para TN.10.27 of explanatory notes to this Category) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20730	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20740	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20745	Initiation of the management of anaesthesia for any of the following: (a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage; (b) endoscopic retrograde cholangiopancreatography; (c) upper gastrointestinal endoscopic ultrasound; (d) percutaneous endoscopic gastrostomy; (e) upper gastrointestinal endoscopic mucosal resection of tumour. (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	6. UPPER ABDOMEN
Fee 20750	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:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20752	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20754	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20756	INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units) **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05
Fee 20770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 20790	Initiation of the management of anaesthesia for procedures within the peritoneal cavity in upper abdomen, including any of the following: (a) open cholecystectomy; (b) gastrectomy; (c) laparoscopically assisted nephrectomy; (d) bowel shunts (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 20791	Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity (10 basic units) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20792	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units) **Fee:** $282.10 **Benefit:** 75% = $211.60 85% = $239.80
Fee 20793	INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 20794	INITIATION OF MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic units) **Fee:** $260.40 **Benefit:** 75% = $195.30 85% = $221.35

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	6. UPPER ABDOMEN
Fee 20798	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the upper abdomen (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20799	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	7. LOWER ABDOMEN
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 7. Lower Abdomen
Fee 20800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 20802	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20803	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20804	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20806	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20810	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	**7. LOWER ABDOMEN**
Fee 20815	INITIATION OF MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to urinary tract (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20820	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20830	INITIATION OF MANAGEMENT OF ANAESTHESIA for hernia repairs in lower abdomen, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20832	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20840	Initiation of the management of anaesthesia for all open procedures within the lower abdominal peritoneal cavity, including appendicectomy, not being a service to which another item in this Subgroup applies (6 basic units) (See para TN.10.27 of explanatory notes to this Category) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20841	INITIATION OF MANAGEMENT OF ANAESTHESIA for bowel resection, including laparoscopic bowel resection not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 20842	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20844	INITIATION OF MANAGEMENT OF ANAESTHESIA for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20845	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20846	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20847	INITIATION OF MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20848	INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20850	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units)

	Fee: $260.40 **Benefit:** 75% = $195.30 85% = $221.35
Fee 20855	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean hysterectomy or hysterectomy within 24 hours of birth (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 20860	INITIATION OF MANAGEMENT OF ANAESTHESIA for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20862	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20863	INITIATION OF MANAGEMENT OF ANAESTHESIA for nephrectomy (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20864	INITIATION OF MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20866	INITIATION OF MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20867	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20868	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient) (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20880	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major lower abdominal vessels, not being a service to which another item in this subgroup applies (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 20882	INITIATION OF MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20884	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20886	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the lower abdomen (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 8. Perineum
Fee 20900	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the perineum not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 20902	Initiation of the management of anaesthesia for anorectal procedures (including surgical haemorrhoidectomy, but not banding of haemorrhoids) (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20904	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20905	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the perineum (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20906	INITIATION OF MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20910	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20911	INITIATION OF MANAGEMENT OF ANAESTHESIA for endoscopic ureteroscopic surgery including laser procedures (5 basic units) (See para TN.10.29 of explanatory notes to this Category) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20912	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder tumour(s) (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20914	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 20916	INITIATION OF MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15

Fee 20920	Initiation of management of anaesthesia for procedures on external genitalia, not being a service to which another item in this Subgroup applies. (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20924	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20926	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20928	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20930	INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20932	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20934	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20936	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 20938	INITIATION OF MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20940	INITIATION OF MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures (including biopsy of vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20942	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	8. PERINEUM
Fee 20943	INITIATION OF MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20944	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 20946	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal birth (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 20948	INITIATION OF MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal of purse string ligature (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20950	INITIATION OF MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20952	INITIATION OF MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20954	INITIATION OF MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 20956	INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 20958	INITIATION OF MANAGEMENT OF ANAESTHESIA for manual removal of retained placenta or for repair of vaginal or perineal tear following birth (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 20960	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15

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

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	**9. PELVIS (EXCEPT HIP)**
Fee 21100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 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:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21112	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21114	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21116	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21130	INITIATION OF MANAGEMENT OF ANAESTHESIA for body cast application or revision when performed in the operating theatre of a hospital (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21140	INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 21150	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21155	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21160	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	9. PELVIS (EXCEPT HIP)
Fee 21170	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis pubis or sacroiliac joint (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	10. UPPER LEG (EXCEPT KNEE)
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 10. Upper Leg (Except Knee)
Fee 21195	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21199	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21200	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21202	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21210	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving hip joint, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21212	INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21214	Initiation of management of anaesthesia for primary total hip replacement. (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21215 S	Initiation of management of anaesthesia for revision total hip replacement (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 21216	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 basic units)

	Fee: $303.80 **Benefit:** 75% = $227.85 85% = $258.25
Fee 21220	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21230	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving upper 2/3 of femur, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21232	INITIATION OF MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21234	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 21260	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21270	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 21272	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21274	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic units) (See para TN.10.24 of explanatory notes to this Category) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21275	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper leg (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21280	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 11. Knee And Popliteal Area
Fee 21300	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21321	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21340	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21360	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21380	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when performed in the operating theatre of a hospital (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21382	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21390	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21392	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21400	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21402	INITIATION OF MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 21403	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	11. KNEE AND POPLITEAL AREA
	Fee: $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21404	INITIATION OF MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21420	INITIATION OF MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair involving knee joint, undertaken in a hospital (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21430	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of knee or popliteal area, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21432	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or popliteal area (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21440	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of knee or popliteal area, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 21445	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the knee and/or popliteal area (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	12. LOWER LEG (BELOW KNEE)
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 12. Lower Leg (Below Knee)
Fee 21460	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21461	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	12. LOWER LEG (BELOW KNEE)
Fee 21462	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21464	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21472	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21474	INITIATION OF MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21480	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21482	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower leg, ankle or foot (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21484	INITIATION OF MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21486	INITIATION OF MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 21490	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or repair, undertaken in a hospital (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21500	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 21502	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21520	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of lower leg, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	12. LOWER LEG (BELOW KNEE)
Fee 21522	INITIATION OF MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21530	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg, ankle or foot (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 21532	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 21535	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the lower leg (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	13. SHOULDER AND AXILLA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 13. Shoulder And Axilla
Fee 21600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21610	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21620	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21622	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	13. SHOULDER AND AXILLA
Fee 21630	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21632	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21634	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units) **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05
Fee 21636	INITIATION OF MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) amputation (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 21638	INITIATION OF MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21650	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of shoulder or axilla, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 21652	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21654	INITIATION OF MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or axilla (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 21656	INITIATION OF MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21670	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21680	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder cast application, removal or repair, not being a service to which another item in this Subgroup applies, when undertaken in a hospital (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	13. SHOULDER AND AXILLA
Fee 21682	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder spica application when undertaken in a hospital (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21685	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the shoulder or the axilla (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	14. UPPER ARM AND ELBOW
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 14. Upper Arm And Elbow
Fee 21700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21710	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21712	INITIATION OF MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21714	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21716	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21730	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the upper arm or elbow when performed in the operating theatre of a hospital (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	14. UPPER ARM AND ELBOW
Fee 21732	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21740	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the upper arm or elbow, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21756	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or elbow (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21760	INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 21770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of upper arm, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 21772	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21780	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of upper arm, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21785	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper arm or elbow (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21790	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	15. FOREARM WRIST AND HAND
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 15. Forearm Wrist And Hand

Fee 21800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21810	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21820	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21830	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21832	INITIATION OF MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 21834	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21840	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 21842	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21850	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21860	INITIATION OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, removal, or repair when rendered to a patient as part of an episode of hospital treatment (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21865	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21870	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm, wrist or hand (15 basic units)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	15. FOREARM WRIST AND HAND
	Fee: $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 21872	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	16. ANAESTHESIA FOR BURNS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 16. Anaesthesia For Burns
Fee 21878	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21879	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting,where the area of burn involves more than 3% but less than 10% of total body surface (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21880	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (7 basic units) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 21881	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units) **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05
Fee 21882	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (11 basic units) **Fee:** $238.70 **Benefit:** 75% = $179.05 85% = $202.90
Fee 21883	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (13 basic units) **Fee:** $282.10 **Benefit:** 75% = $211.60 85% = $239.80

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	16. ANAESTHESIA FOR BURNS
Fee 21884	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 21885	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units) **Fee:** $368.90 **Benefit:** 75% = $276.70 85% = $313.60
Fee 21886	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units) **Fee:** $412.30 **Benefit:** 75% = $309.25 85% = $350.50
Fee 21887	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic units) **Fee:** $455.70 **Benefit:** 75% = $341.80 85% = $387.35

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 17. Anaesthesia For Radiological Or Other Diagnostic Or Therapeutic Procedures
Fee 21900	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for hysterosalpingography (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21906	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21908	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: cervical (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21910	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units) **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05

Fee 21912	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: lumbar or thoracic (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21914	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: cervical (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21915	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21916	INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21918	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21922	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21925	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21926	INITIATION OF MANAGEMENT OF ANAESTHESIA for fluoroscopy (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21930	INITIATION OF MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 21935	INITIATION OF MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21936	INITIATION OF MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time transoesophageal examination (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21939	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35

Fee 21941	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker (7 basic units) (See para TN.10.25 of explanatory notes to this Category) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 21942	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures including radio frequency ablation (10 basic units) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 21943	INITIATION OF MANAGEMENT OF ANAESTHESIA for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21945	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or epidural injection (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21949	INITIATION OF MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose of transplantation (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21952	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21955	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21959	INITIATION OF MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21962	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21965	INITIATION OF MANAGEMENT OF ANAESTHESIA as a therapeutic procedure if there is a clinical need for anaesthesia, not for headache of any etiology (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21969	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
Fee 21970	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (15 basic units) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 21973	INITIATION OF MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed sources (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21976	INITIATION OF MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 21980	INITIATION OF MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	18. MISCELLANEOUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 18. Miscellaneous
Fee 21990	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units) (See para TN.10.12 of explanatory notes to this Category) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 21992	INITIATION OF MANAGEMENT OF ANAESTHESIA performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 21997	INITIATION OF MANAGEMENT OF ANAESTHESIA in connection with a procedure covered by an item that does not include the word "(Anaes.)", other than a service to which item 21965 or 21992 applies, if there is a clinical need for anaesthesia (4 basic units) (See para TN.10.13 of explanatory notes to this Category) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 19. Therapeutic And Diagnostic Services
Fee 22002	Administration of homologous blood or bone marrow already collected, when performed in association with the management of anaesthesia (4 basic units) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 22007	ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 22008	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 22012	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient: (a) when performed in association with the management of anaesthesia for the patient; and (b) other than a service to which item 13876 applies (c) is categorised as having a high risk of complications or during the procedure develops either complications or a high risk of complications (3 basic units) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 22014	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) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 22015	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the administration of anaesthesia (6 basic units) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 22020	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) (See para TN.1.6, TN.10.8 of explanatory notes to this Category) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80

	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) (See para TN.10.8 of explanatory notes to this Category)
Fee 22025	**Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
	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) (See para TN.10.17 of explanatory notes to this Category)
Fee 22031	**Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
	INTRATHECAL or EPIDURAL INJECTION (subsequent) of a therapeutic substance or substances, using an in-situ catheter, in association with anaesthesia and surgery, for postoperative pain management, not being a service associated with a service to which 22031 applies (3 basic units) (See para TN.10.17 of explanatory notes to this Category)
Fee 22036	**Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
	Perioperative introduction of a plexus or nerve block proximal to the lower leg or forearm for post operative pain management (2 basic units) (See para TN.10.17 of explanatory notes to this Category)
Fee 22041	**Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
	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) (See para TN.10.8 of explanatory notes to this Category)
Fee 22042	**Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
	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) (See para TN.10.30 of explanatory notes to this Category)
Fee 22051	**Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05
	PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units) (See para TN.10.10 of explanatory notes to this Category)
Fee 22055	**Fee:** $260.40 **Benefit:** 75% = $195.30 85% = $221.35
	WHOLE BODY PERFUSION, CARDIAC BYPASS, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies (Anaes.) (30 basic units) (See para TN.10.10 of explanatory notes to this Category)
Fee 22060	**Fee:** $651.00 **Benefit:** 75% = $488.25 85% = $557.80

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	19. THERAPEUTIC AND DIAGNOSTIC SERVICES
Fee 22065	INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units) (See para TN.10.10 of explanatory notes to this Category) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 22075	DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units) (See para TN.10.10 of explanatory notes to this Category) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	20. ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 20. Administration Of Anaesthesia In Connection With A Dental Service
Fee 22900	INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units) (See para TN.10.14 of explanatory notes to this Category) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 22905	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units) (See para TN.10.14 of explanatory notes to this Category) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE 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
Fee 23010	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA (a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or

	(b) perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 For a period of: (FIFTEEN MINUTES OR LESS) (1 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
Fee 23025	16 MINUTES TO 30 MINUTES (2 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
Fee 23035	31 MINUTES to 45 MINUTES (3 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35
Fee 23045	46 MINUTES to 1:00 HOUR (4 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $86.80 **Benefit:** 75% = $65.10 85% = $73.80
Fee 23055	1:01 HOURS to 1:15 HOURS (5 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $108.50 **Benefit:** 75% = $81.40 85% = $92.25
Fee 23065	1:16 HOURS to 1:30 HOURS (6 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
Fee 23075	1:31 HOURS to 1:45 HOURS (7 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
Fee 23085	1:46 HOURS to 2:00 HOURS (8 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $173.60 **Benefit:** 75% = $130.20 85% = $147.60
Fee 23091	2:01 HOURS TO 2:10 HOURS (9 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $195.30 **Benefit:** 75% = $146.50 85% = $166.05
Fee 23101	2:11 HOURS TO 2:20 HOURS (10 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $217.00 **Benefit:** 75% = $162.75 85% = $184.45
Fee 23111	2:21 HOURS TO 2:30 HOURS (11 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $238.70 **Benefit:** 75% = $179.05 85% = $202.90
Fee 23112	2:31 HOURS TO 2:40 HOURS (12 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $260.40 **Benefit:** 75% = $195.30 85% = $221.35
Fee 23113	2:41 HOURS TO 2:50 HOURS (13 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $282.10 **Benefit:** 75% = $211.60 85% = $239.80
Fee 23114	2:51 HOURS TO 3:00 HOURS (14 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $303.80 **Benefit:** 75% = $227.85 85% = $258.25
Fee 23115	3:01 HOURS TO 3:10 HOURS (15 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
Fee 23116	3:11 HOURS TO 3:20 HOURS (16 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $347.20 **Benefit:** 75% = $260.40 85% = $295.15
Fee 23117	3:21 HOURS TO 3:30 HOURS (17 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $368.90 **Benefit:** 75% = $276.70 85% = $313.60
Fee 23118	3:31 HOURS TO 3:40 HOURS (18 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $390.60 **Benefit:** 75% = $292.95 85% = $332.05
Fee 23119	3:41 HOURS TO 3:50 HOURS (19 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $412.30 **Benefit:** 75% = $309.25 85% = $350.50
Fee 23121	3:51 HOURS TO 4:00 HOURS (20 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $434.00 **Benefit:** 75% = $325.50 85% = $368.90
Fee 23170	4:01 HOURS TO 4:10 HOURS (21 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $455.70 **Benefit:** 75% = $341.80 85% = $387.35
Fee 23180	4:11 HOURS TO 4:20 HOURS (22 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $477.40 **Benefit:** 75% = $358.05 85% = $405.80
Fee 23190	4:21 HOURS TO 4:30 HOURS (23 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $499.10 **Benefit:** 75% = $374.35 85% = $424.25
Fee 23200	4:31 HOURS TO 4:40 HOURS (24 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $520.80 **Benefit:** 75% = $390.60 85% = $442.70
Fee 23210	4:41 HOURS TO 4:50 HOURS (25 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $542.50 **Benefit:** 75% = $406.90 85% = $461.15
Fee 23220	4:51 HOURS TO 5:00 HOURS (26 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $564.20 **Benefit:** 75% = $423.15 85% = $479.60
Fee 23230	5:01 HOURS TO 5:10 HOURS (27 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $585.90 **Benefit:** 75% = $439.45 85% = $498.05
Fee 23240	5:11 HOURS TO 5:20 HOURS (28 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $607.60 **Benefit:** 75% = $455.70 85% = $516.50
Fee 23250	5:21 HOURS TO 5:30 HOURS (29 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $629.30 **Benefit:** 75% = $472.00 85% = $536.10
Fee 23260	5:31 HOURS TO 5:40 HOURS (30 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $651.00 **Benefit:** 75% = $488.25 85% = $557.80
Fee 23270	5:41 HOURS TO 5:50 HOURS (31 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $672.70 **Benefit:** 75% = $504.55 85% = $579.50
Fee 23280	(5:51 HOURS TO 6:00 HOURS (32 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $694.40 **Benefit:** 75% = $520.80 85% = $601.20
Fee 23290	6:01 HOURS TO 6:10 HOURS (33 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $716.10 **Benefit:** 75% = $537.10 85% = $622.90
Fee 23300	6:11 HOURS TO 6:20 HOURS (34 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $737.80 **Benefit:** 75% = $553.35 85% = $644.60
Fee 23310	6:21 HOURS TO 6:30 HOURS (35 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $759.50 **Benefit:** 75% = $569.65 85% = $666.30
Fee 23320	6:31 HOURS TO 6:40 HOURS (36 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $781.20 **Benefit:** 75% = $585.90 85% = $688.00
Fee 23330	6:41 HOURS TO 6:50 HOURS (37 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $802.90 **Benefit:** 75% = $602.20 85% = $709.70
Fee 23340	6:51 HOURS TO 7:00 HOURS (38 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $824.60 **Benefit:** 75% = $618.45 85% = $731.40
Fee 23350	7:01 HOURS TO 7:10 HOURS (39 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $846.30 **Benefit:** 75% = $634.75 85% = $753.10
Fee 23360	7:11 HOURS TO 7:20 HOURS (40 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $868.00 **Benefit:** 75% = $651.00 85% = $774.80
Fee 23370	7:21 HOURS TO 7:30 HOURS (41 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $889.70 **Benefit:** 75% = $667.30 85% = $796.50
Fee 23380	7:31 HOURS TO 7:40 HOURS (42 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $911.40 **Benefit:** 75% = $683.55 85% = $818.20
Fee 23390	7:41 HOURS TO 7:50 HOURS (43 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $933.10 **Benefit:** 75% = $699.85 85% = $839.90
Fee 23400	7:51 HOURS TO 8:00 HOURS (44 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $954.80 **Benefit:** 75% = $716.10 85% = $861.60
Fee 23410	8:01 HOURS TO 8:10 HOURS (45 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $976.50 **Benefit:** 75% = $732.40 85% = $883.30
Fee 23420	8:11 HOURS TO 8:20 HOURS (46 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $998.20 **Benefit:** 75% = $748.65 85% = $905.00
Fee 23430	8:21 HOURS TO 8:30 HOURS (47 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,019.90 **Benefit:** 75% = $764.95 85% = $926.70
Fee 23440	8:31 HOURS TO 8:40 HOURS (48 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,041.60 **Benefit:** 75% = $781.20 85% = $948.40
Fee 23450	8:41 HOURS TO 8:50 HOURS (49 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,063.30 **Benefit:** 75% = $797.50 85% = $970.10
Fee 23460	8:51 HOURS TO 9:00 HOURS (50 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,085.00 **Benefit:** 75% = $813.75 85% = $991.80
Fee 23470	9:01 HOURS TO 9:10 HOURS (51 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,106.70 **Benefit:** 75% = $830.05 85% = $1013.50
Fee 23480	9:11 HOURS TO 9:20 HOURS (52 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,128.40 **Benefit:** 75% = $846.30 85% = $1035.20
Fee 23490	9:21 HOURS TO 9:30 HOURS (53 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,150.10 **Benefit:** 75% = $862.60 85% = $1056.90
Fee 23500	9:31 HOURS TO 9:40 HOURS (54 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,171.80 **Benefit:** 75% = $878.85 85% = $1078.60
Fee 23510	9:41 HOURS TO 9:50 HOURS (55 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,193.50 **Benefit:** 75% = $895.15 85% = $1100.30
Fee 23520	9:51 HOURS TO 10:00 HOURS (56 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,215.20 **Benefit:** 75% = $911.40 85% = $1122.00
Fee 23530	10:01 HOURS TO 10:10 HOURS (57 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,236.90 **Benefit:** 75% = $927.70 85% = $1143.70
Fee 23540	10:11 HOURS TO 10:20 HOURS (58 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $1,258.60 **Benefit:** 75% = $943.95 85% = $1165.40
Fee 23550	10:21 HOURS TO 10:30 HOURS (59 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,280.30 **Benefit:** 75% = $960.25 85% = $1187.10
Fee 23560	10:31 HOURS TO 10:40 HOURS (60 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,302.00 **Benefit:** 75% = $976.50 85% = $1208.80
Fee 23570	10:41 HOURS TO 10:50 HOURS (61 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,323.70 **Benefit:** 75% = $992.80 85% = $1230.50
Fee 23580	10:51 HOURS TO 11:00 HOURS (62 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,345.40 **Benefit:** 75% = $1009.05 85% = $1252.20
Fee 23590	11:01 HOURS TO 11:10 HOURS (63 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,367.10 **Benefit:** 75% = $1025.35 85% = $1273.90
Fee 23600	11:11 HOURS TO 11:20 HOURS (64 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,388.80 **Benefit:** 75% = $1041.60 85% = $1295.60
Fee 23610	11:21 HOURS TO 11:30 HOURS (65 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,410.50 **Benefit:** 75% = $1057.90 85% = $1317.30
Fee 23620	11:31 HOURS TO 11:40 HOURS (66 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,432.20 **Benefit:** 75% = $1074.15 85% = $1339.00
Fee 23630	11:41 HOURS TO 11:50 HOURS (67 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,453.90 **Benefit:** 75% = $1090.45 85% = $1360.70
Fee 23640	11:51 HOURS TO 12:00 HOURS (68 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,475.60 **Benefit:** 75% = $1106.70 85% = $1382.40
Fee 23650	12:01 HOURS TO 12:10 HOURS (69 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,497.30 **Benefit:** 75% = $1123.00 85% = $1404.10
Fee 23660	12:11 HOURS TO 12:20 HOURS (70 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $1,519.00 **Benefit:** 75% = $1139.25 85% = $1425.80
Fee 23670	12:21 HOURS TO 12:30 HOURS (71 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,540.70 **Benefit:** 75% = $1155.55 85% = $1447.50
Fee 23680	12:31 HOURS TO 12:40 HOURS (72 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,562.40 **Benefit:** 75% = $1171.80 85% = $1469.20
Fee 23690	12:41 HOURS TO 12:50 HOURS (73 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,584.10 **Benefit:** 75% = $1188.10 85% = $1490.90
Fee 23700	12:51 HOURS TO 13:00 HOURS (74 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,605.80 **Benefit:** 75% = $1204.35 85% = $1512.60
Fee 23710	13:01 HOURS TO 13:10 HOURS (75 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,627.50 **Benefit:** 75% = $1220.65 85% = $1534.30
Fee 23720	13:11 HOURS TO 13:20 HOURS (76 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,649.20 **Benefit:** 75% = $1236.90 85% = $1556.00
Fee 23730	13:21 HOURS TO 13:30 HOURS (77 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,670.90 **Benefit:** 75% = $1253.20 85% = $1577.70
Fee 23740	13:31 HOURS TO 13:40 HOURS (78 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,692.60 **Benefit:** 75% = $1269.45 85% = $1599.40
Fee 23750	13:41 HOURS TO 13:50 HOURS (79 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,714.30 **Benefit:** 75% = $1285.75 85% = $1621.10
Fee 23760	13:51 HOURS TO 14:00 HOURS (80 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,736.00 **Benefit:** 75% = $1302.00 85% = $1642.80
Fee 23770	14:01 HOURS TO 14:10 HOURS (81 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,757.70 **Benefit:** 75% = $1318.30 85% = $1664.50
Fee 23780	14:11 HOURS TO 14:20 HOURS (82 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $1,779.40 **Benefit:** 75% = $1334.55 85% = $1686.20
Fee 23790	14:21 HOURS TO 14:30 HOURS (83 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,801.10 **Benefit:** 75% = $1350.85 85% = $1707.90
Fee 23800	14:31 HOURS TO 14:40 HOURS (84 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,822.80 **Benefit:** 75% = $1367.10 85% = $1729.60
Fee 23810	14:41 HOURS TO 14:50 HOURS (85 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,844.50 **Benefit:** 75% = $1383.40 85% = $1751.30
Fee 23820	14:51 HOURS TO 15:00 HOURS (86 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,866.20 **Benefit:** 75% = $1399.65 85% = $1773.00
Fee 23830	15:01 HOURS TO 15:10 HOURS (87 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,887.90 **Benefit:** 75% = $1415.95 85% = $1794.70
Fee 23840	15:11 HOURS TO 15:20 HOURS (88 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,909.60 **Benefit:** 75% = $1432.20 85% = $1816.40
Fee 23850	15:21 HOURS TO 15:30 HOURS (89 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,931.30 **Benefit:** 75% = $1448.50 85% = $1838.10
Fee 23860	15:31 HOURS TO 15:40 HOURS (90 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,953.00 **Benefit:** 75% = $1464.75 85% = $1859.80
Fee 23870	15:41 HOURS TO 15:50 HOURS (91 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,974.70 **Benefit:** 75% = $1481.05 85% = $1881.50
Fee 23880	15:51 HOURS TO 16:00 HOURS (92 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,996.40 **Benefit:** 75% = $1497.30 85% = $1903.20
Fee 23890	16:01 HOURS TO 16:10 HOURS (93 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,018.10 **Benefit:** 75% = $1513.60 85% = $1924.90
Fee 23900	16:11 HOURS TO 16:20 HOURS (94 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $2,039.80 **Benefit:** 75% = $1529.85 85% = $1946.60
Fee 23910	16:21 HOURS TO 16:30 HOURS (95 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,061.50 **Benefit:** 75% = $1546.15 85% = $1968.30
Fee 23920	16:31 HOURS TO 16:40 HOURS (96 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,083.20 **Benefit:** 75% = $1562.40 85% = $1990.00
Fee 23930	16:41 HOURS TO 16:50 HOURS (97 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,104.90 **Benefit:** 75% = $1578.70 85% = $2011.70
Fee 23940	16:51 HOURS TO 17:00 HOURS (98 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,126.60 **Benefit:** 75% = $1594.95 85% = $2033.40
Fee 23950	17:01 HOURS TO 17:10 HOURS (99 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,148.30 **Benefit:** 75% = $1611.25 85% = $2055.10
Fee 23960	17:11 HOURS TO 17:20 HOURS (100 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,170.00 **Benefit:** 75% = $1627.50 85% = $2076.80
Fee 23970	17:21 HOURS TO 17:30 HOURS (101 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,191.70 **Benefit:** 75% = $1643.80 85% = $2098.50
Fee 23980	17:31 HOURS TO 17:40 HOURS (102 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,213.40 **Benefit:** 75% = $1660.05 85% = $2120.20
Fee 23990	17:41 HOURS TO 17:50 HOURS (103 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,235.10 **Benefit:** 75% = $1676.35 85% = $2141.90
Fee 24100	17:51 HOURS TO 18:00 HOURS (104 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,256.80 **Benefit:** 75% = $1692.60 85% = $2163.60
Fee 24101	18:01 HOURS TO 18:10 HOURS (105 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,278.50 **Benefit:** 75% = $1708.90 85% = $2185.30
Fee 24102	18:11 HOURS TO 18:20 HOURS (106 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $2,300.20 **Benefit:** 75% = $1725.15 85% = $2207.00
Fee 24103	18:21 HOURS TO 18:30 HOURS (107 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,321.90 **Benefit:** 75% = $1741.45 85% = $2228.70
Fee 24104	18:31 HOURS TO 18:40 HOURS (108 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,343.60 **Benefit:** 75% = $1757.70 85% = $2250.40
Fee 24105	18:41 HOURS TO 18:50 HOURS (109 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,365.30 **Benefit:** 75% = $1774.00 85% = $2272.10
Fee 24106	18:51 HOURS TO 19:00 HOURS (110 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,387.00 **Benefit:** 75% = $1790.25 85% = $2293.80
Fee 24107	19:01 HOURS TO 19:10 HOURS (111 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,408.70 **Benefit:** 75% = $1806.55 85% = $2315.50
Fee 24108	19:11 HOURS TO 19:20 HOURS (112 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,430.40 **Benefit:** 75% = $1822.80 85% = $2337.20
Fee 24109	19:21 HOURS TO 19:30 HOURS (113 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,452.10 **Benefit:** 75% = $1839.10 85% = $2358.90
Fee 24110	19:31 HOURS TO 19:40 HOURS (114 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,473.80 **Benefit:** 75% = $1855.35 85% = $2380.60
Fee 24111	19:41 HOURS TO 19:50 HOURS (115 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,495.50 **Benefit:** 75% = $1871.65 85% = $2402.30
Fee 24112	19:51 HOURS TO 20:00 HOURS (116 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,517.20 **Benefit:** 75% = $1887.90 85% = $2424.00
Fee 24113	20:01 HOURS TO 20:10 HOURS (117 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,538.90 **Benefit:** 75% = $1904.20 85% = $2445.70
Fee 24114	20:11 HOURS TO 20:20 HOURS (118 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $2,560.60 **Benefit:** 75% = $1920.45 85% = $2467.40
Fee 24115	20:21 HOURS TO 20:30 HOURS (119 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,582.30 **Benefit:** 75% = $1936.75 85% = $2489.10
Fee 24116	20:31 HOURS TO 20:40 HOURS (120 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,604.00 **Benefit:** 75% = $1953.00 85% = $2510.80
Fee 24117	20:41 HOURS TO 20:50 HOURS (121 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,625.70 **Benefit:** 75% = $1969.30 85% = $2532.50
Fee 24118	20:51 HOURS TO 21:00 HOURS (122 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,647.40 **Benefit:** 75% = $1985.55 85% = $2554.20
Fee 24119	21:01 HOURS TO 21:10 HOURS (123 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,669.10 **Benefit:** 75% = $2001.85 85% = $2575.90
Fee 24120	21:11 HOURS TO 21:20 HOURS (124 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,690.80 **Benefit:** 75% = $2018.10 85% = $2597.60
Fee 24121	21:21 HOURS TO 21:30 HOURS (125 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,712.50 **Benefit:** 75% = $2034.40 85% = $2619.30
Fee 24122	21:31 HOURS TO 21:40 HOURS (126 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,734.20 **Benefit:** 75% = $2050.65 85% = $2641.00
Fee 24123	21:41 HOURS TO 21:50 HOURS (127 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,755.90 **Benefit:** 75% = $2066.95 85% = $2662.70
Fee 24124	21:51 HOURS TO 22:00 HOURS (128 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,777.60 **Benefit:** 75% = $2083.20 85% = $2684.40
Fee 24125	22:01 HOURS TO 22:10 HOURS (129 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,799.30 **Benefit:** 75% = $2099.50 85% = $2706.10
Fee 24126	22:11 HOURS TO 22:20 HOURS (130 basic units) (See para TN.10.3 of explanatory notes to this Category)

	Fee: $2,821.00 **Benefit:** 75% = $2115.75 85% = $2727.80
Fee 24127	22:21 HOURS TO 22:30 HOURS (131 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,842.70 **Benefit:** 75% = $2132.05 85% = $2749.50
Fee 24128	22:31 HOURS TO 22:40 HOURS (132 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,864.40 **Benefit:** 75% = $2148.30 85% = $2771.20
Fee 24129	22:41 HOURS TO 22:50 HOURS (133 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,886.10 **Benefit:** 75% = $2164.60 85% = $2792.90
Fee 24130	22:51 HOURS TO 23:00 HOURS (134 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,907.80 **Benefit:** 75% = $2180.85 85% = $2814.60
Fee 24131	23:01 HOURS TO 23:10 HOURS (135 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,929.50 **Benefit:** 75% = $2197.15 85% = $2836.30
Fee 24132	23:11 HOURS TO 23:20 HOURS (136 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,951.20 **Benefit:** 75% = $2213.40 85% = $2858.00
Fee 24133	23:21 HOURS TO 23:30 HOURS (137 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,972.90 **Benefit:** 75% = $2229.70 85% = $2879.70
Fee 24134	23:31 HOURS TO 23:40 HOURS (138 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,994.60 **Benefit:** 75% = $2245.95 85% = $2901.40
Fee 24135	23:41 HOURS TO 23:50 HOURS (139 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,016.30 **Benefit:** 75% = $2262.25 85% = $2923.10
Fee 24136	23:51 HOURS TO 24:00 HOURS (140 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,038.00 **Benefit:** 75% = $2278.50 85% = $2944.80

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
	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
Fee 25000	ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA (a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) for perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units) **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
Fee 25005	Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
Fee 25010	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to ASA physical status indicator 5 (3 basic units) **Fee:** $65.10 **Benefit:** 75% = $48.85 85% = $55.35

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
Fee 25013 S	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged under 4 years (Anaes.) (1 basic units) **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
Fee 25014 S	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more (Anaes.) (1 basic units) **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
Fee 25020	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	23. ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER
	- where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 basic units) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90

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
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 24. Anaesthesia After Hours Emergency Modifier
Fee 25025	Anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (0 basic units) **Derived Fee:** An additional amount of 50% of fee for the anaesthetic service.That is:(a) an anaesthesia item/s range 20100 - 21997 or 22900, plus (b)an item range 23010 - 24136, plus(c) if applicable,an item range 25000-25014, plus(d) where performed, any assoc therapeutic or diagnostic service range 22002-22051
Fee 25030	Assistance in the management of anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (0 basic units) **Derived Fee:** 50% of the fee for assistance at anaesthesia. That is: (a) an assistant anaesthesia item in the range 25200 - 25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (d) where performed, any associated therapeutic or diagnostic service 22002 -22051

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE 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
Fee 25050	Perfusion, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday. (0 basic units)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	25. PERFUSION AFTER HOURS EMERGENCY MODIFIER
	Derived Fee: An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item range 23010 - 24136, plus (c) where applicable, an item range 25000 - 25014, plus (d) where performed, any associated therapeutic or diagnostic service in the range 22002-22051 or 22065-22075

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	26. ASSISTANCE AT ANAESTHESIA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 26. Assistance At Anaesthesia
Fee 25200	ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (5 basic units) (See para TN.10.9 of explanatory notes to this Category) **Derived Fee:** An amount of $108.50 (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
Fee 25205	ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA where: (i) the patient has complex airway problems; or (ii) the patient is a neonate or a complex paediatric case; or (iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (iv) the patient is critically ill, with multiple organ failure; or (v) where the anaesthesia time exceeds 6 hours and the assistance is provided to the exclusion of all other patients (5 basic units) (See para TN.10.9 of explanatory notes to this Category) **Derived Fee:** An amount of $108.50 (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. BOTULINUM TOXIN INJECTIONS	
	Group T11. Botulinum Toxin Injections
Fee 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:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18351	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:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18353	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of cervical dystonia (spasmodic torticollis), including all such injections on any one day (See para TN.11.1 of explanatory notes to this Category) **Fee:** $273.50 **Benefit:** 75% = $205.15 85% = $232.50
Fee 18354	Botulinum Toxin Type A Purified Neurotixin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of dynamic equinus foot deformity (including equinovarus and equinovalgus) due to spasticity in an ambulant cerebral palsy 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, TN.7.5 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18360	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 (See para TN.11.1 of explanatory notes to this Category)

T11. BOTULINUM TOXIN INJECTIONS	
	Fee: $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18361	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if: (a) the patient is at least 2 years of age; and (b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18362	Botulinum Toxin type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of severe primary axillary hyperhidrosis, including all injections on any one day, if: (a) the patient is at least 12 years of age; and (b) the patient has been intolerant of, or has not responded to, topical aluminium chloride hexahydrate; and (c) the patient has not had treatment with botulinum toxin within the immediately preceding 4 months; and (d) if the patient has had treatment with botulinum toxin within the previous 12 months - the patient had treatment on no more than 2 separate occasions (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $270.20 **Benefit:** 75% = $202.65 85% = $229.70
Fee 18365	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of moderate to severe spasticity of the upper limb following an acute event, if: (a) the patient is at least 18 years of age; and (b) treatment is provided as: (i) second line therapy when standard treatment for the condition has failed; or (ii) an adjunct to physical therapy; and (c) the patient does not have established severe contracture in the limb that is to be treated; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and (e) for a patient who has received treatment on 2 previous separate occasions - the patient has responded to the treatment (See para TN.11.1 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18366	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.)

T11. BOTULINUM TOXIN INJECTIONS	
	(See para TN.11.1 of explanatory notes to this Category) **Fee:** $171.30 **Benefit:** 75% = $128.50 85% = $145.65
Fee 18368	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day (See para TN.11.1 of explanatory notes to this Category) **Fee:** $292.45 **Benefit:** 75% = $219.35 85% = $248.60
Fee 18369	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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95
Fee 18370	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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95
Fee 18372	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18374	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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18375	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

T11. BOTULINUM TOXIN INJECTIONS	
	(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 For each patient - applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $251.80 **Benefit:** 75% = $188.85
Fee 18377	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) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $136.75 **Benefit:** 75% = $102.60 85% = $116.25
Fee 18379	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

T11. BOTULINUM TOXIN INJECTIONS	
	(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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $251.80 **Benefit:** 75% = $188.85