Australian Government

Department of Health

Medicare Benefits Schedule Book

Category 3

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Title: Medicare Benefits Schedule Book

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

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

TABLE OF CONTENTS

GENERAL EXPLANATORY NOTES

GENERAL EXPLANATORY NOTES

GN.0.1 AskMBS Email Advice Service

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

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

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

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

GN.1.1 The Medicare Benefits Schedule - Introduction

Schedules of Services

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

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

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

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

Explanatory Notes

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

GN.1.2 Medicare - an outline

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

a. Free treatment for public patients in public hospitals.
b. The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are
    i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;

ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or Aboriginal and Torres Strait Islander health practitioner;
iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

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

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

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

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

GN.1.3 Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

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

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

Billing practices contrary to the Act

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

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

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

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

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

(a) No Medicare benefits will be paid for the service;

(b) The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.

(c) Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

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

The Department of Human Services (DHS) has developed a 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 DHS website.

GN.2.4 Provider eligibility for Medicare

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

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

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

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

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

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

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

Non-medical practitioners

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

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

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

GN.2.5 Provider Numbers

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

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

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

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

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

GN.2.6 Locum tenens

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

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

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

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

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

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

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

GN.2.7 Overseas trained doctor

Ten year moratorium

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

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

Exclusions - Practitioners who before 1 January 1997 had

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

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

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

GN.2.8 Contact details for Services Australia

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

Changes to Provider Contact Details

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

Medicare

GPO Box 9822

in your capital city

or

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

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

GN.3.9 Patient eligibility for Medicare

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

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

GN.3.10 Medicare cards

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

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

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

GN.3.11 Visitors to Australia and temporary residents

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

GN.3.12 Reciprocal Health Care Agreements

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

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

Exceptions:

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

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

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

GN.4.13 General Practice

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

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

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

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

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

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

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

Vocational recognition of general practitioners

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

(a) certification by the RACGP that the practitioner

· is a Fellow of the RACGP; and

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

· 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 the Department of Human Services using the approved Application Form available on the the Department of Human Services website: www.humanservices.gov.au. Applicants should forward their applications, as appropriate, to

The Secretariat

The General Practice Recognition Eligibility Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprec@health.gov.au

The Secretariat

The General Practice Recognition Appeal Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprac@health.gov.au

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

Continued vocational recognition is dependent upon:

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

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

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

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

Removal of vocational recognition status

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

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

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

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

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

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

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

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

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

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

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

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

GN.5.15 Emergency Medicine

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

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

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

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

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

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

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

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

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

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

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

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

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

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

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

What is a Referral?

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

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

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

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

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

The exceptions to the requirements in paragraph above are that

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

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

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

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

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

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

Examination by Specialist Anaesthetists

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

Who can Refer?

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

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

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:

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

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

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

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

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

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

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

Billing

Routine Referrals

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

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

- date of referral; and

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

Special Circumstances

(i) Lost, stolen or destroyed referrals.

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

(ii) Emergencies

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

(iii) Hospital referrals.

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

Public Hospital Patients

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

Bulk Billing

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

Period for which Referral is Valid

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

Specialist Referrals

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

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

Referrals by other Practitioners

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

Definition of a Single Course of Treatment

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

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

The receipt by a specialist or consultant physician of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving

the itemisation of an initial consultation. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the specialist or the consultant physician referred rates rather than the unreferred rates.

However, where the referring practitioner:-

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

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

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

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

Retention of Referral Letters

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

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

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

Attendance for Issuing of a Referral

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

Locum-tenens Arrangements

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

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

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

Self Referral

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

GN.7.17 Billing procedures

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

Bulk billing

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

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

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

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

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

GN.8.18 Provision for review of individual health professionals

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

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

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

Following a review, the Director must:

decide to take no further action; or

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

refer the matter to a PSR Committee.

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

The Committee is authorized to:

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

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

require the production of documents (including clinical notes).

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

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

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

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

an unusual occurrence;

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

the characteristics of the patients.

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

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

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

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

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

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

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

GN.10.27 Medicare safety nets

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

Original Medicare Safety Net:

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2021 is $481.20. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

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

In 2021, the threshold for singles and families that hold a Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB (A) is $697.00. The threshold for all other singles and families in 2021 is $2,184.30.

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

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

EMSN Benefit Caps:

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

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

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

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

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

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

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

GN.11.29 Ministerial Determinations

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

GN.12.30 Professional services

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

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

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

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

(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13750-13760, 13950, 14050, 14218, 14221 and 14245);

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

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

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

(g) All Group T6 (Anaesthetics) items;

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

(i) All Group T8 (Operations) items;

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

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

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

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

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

GN.12.31 Services rendered on behalf of medical practitioners

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

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

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

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

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

Supervision from outside of Australia is not acceptable.

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

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

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

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

GN.12.32 Medicare benefits and vaccinations

Where a medical practitioner administers an injection for immunisation purposes on the medical practioner's own patient, Medicare benefits for that service would be payable on a consultation basis, that is, for the attendance at which the injection is given. However, the cost of the vaccine itself does not attract a Medicare rebate. The Medicare benefits arrangements cover only the professional component of the medical practitioner's service. There are some

circumstances where a Medicare benefit is not payable when a medical practitioner administers an injection for immunisation purposes – please refer to example 3 below for further details.

Example 1

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

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

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

Example 2

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

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

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

Example 3

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

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

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

GN.13.33 Services which do not attract Medicare benefits

Services not attracting benefits

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

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

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

(d) non-therapeutic cosmetic surgery;

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

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

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

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

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

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

Unless the Minister otherwise directs

Medicare benefits are not payable where:

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

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

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

(d) the service is a health screening service.

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

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

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

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

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

(d) the removal of tattoos;

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

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

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

Pain pumps for post-operative pain management

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

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

Non Medicare Services

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

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

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

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

(b) gamma knife surgery;

(c) intradiscal electro thermal arthroplasty;

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

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

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

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

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

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

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

(k) specific mass measurement of bone alkaline phosphatase;

(l) transmyocardial laser revascularisation;

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

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

(o) vertebroplasty;

(p) extracorporeal magnetic innervation.

Health Screening Services

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

(a) multiphasic health screening;

(b) mammography screening (except as provided for in Items 59300/59303);

(c) testing of fitness to undergo physical training program, vocational activities or weight reduction programs;

(d) compulsory examinations and tests to obtain a flying, commercial driving or other licence;

(e) entrance to schools and other educational facilities;

(f) for the purposes of legal proceedings;

(g) compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

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

(a) a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a cervical screening test in a person (see General Explanatory note 12.3 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check-up should not necessarily be accompanied by an extensive battery of diagnostic investigations;

(b) a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;

(c) age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;

(d) a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;

(e) a medical examination for a person as a prerequisite of that person becoming eligible to foster a child or children;

(f) a medical examination being a requisite for Social Security benefits or allowances;

(g) a medical or optometrical examination provided to a person who is an unemployed person (as defined by the Social Security Act 1991), as the request of a prospective employer.

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

(a) Cervical screening should be undertaken every five years in asymptomatic persons, using a primary human papillomavirus (HPV) test with partial genotyping and reflex liquid based cytology (LBC) triage;

(b) Persons who have ever been sexually active should commence cervical screening at 25 years of age;

(c) Persons aged 25 years or older and less than 70 years will receive invitations and reminders to participate in the program;

(d) Persons will be invited to exit the program by having a HPV test between 70 years or older and less than 75 years of age and may cease cervical screening if their test result is low risk;

(e) Persons 75 years of age or older who have either never had a cervical screening test or have not had one in the previous five years, may request a cervical screening test and can be screened;

(f) All persons, both HPV vaccinated and unvaccinated, are included in the program;

(g) Self collection of a sample for testing is available for persons who are aged 30 years and over and has never participated in the NCSP; or is overdue for cervical screening by two years or longer.

· Self collection must be facilitated and requested by a healthcare professional who also routinely offers cervical screening services;

· The self collection device and the HPV test, when used together, must meet the requirements of the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Laboratories Reporting Tests for the NCSP; and

(h) Persons with intermediate and higher risk screening test results should be followed up in accordance with the cervical screening pathway and the NCSP: Guidelines for the management of screen detected abnormalities, screening women in specific populations and investigation of women with abnormal vaginal bleeding (2016 Guidelines) – endorsed by the Royal Australian College of General Practitioners, the Royal Australian and New

Zealand College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Society of Gynaecologic Oncologists and the Australian Society for Colposcopy and Cervical Pathology.

Note 1: As separate items exist for routine screening, screening in specific population and investigation of persons with abnormal vaginal bleeding, treating practitioners are asked to clearly identify on the request form, if the sample is collected as part of routine screening or for another purpose (see paragraph PP.16.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: Where reflex cytology is performed following the detection of HPV in routine screening, the HPV test and the LBC test results must be issued as a combined report with the overall risk rating.

Note 3: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 - Professional Attendances and the associated explanatory notes for these items in Category 1 - Professional Attendances.

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

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

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

(a) a spouse, in relation to a dependant person means:

a. a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and

b. a de facto spouse of that person.

(b) a child, in relation to a dependant person means:

a. a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

b. a person who:

(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or

(ii) is receiving full time education at a school, college or university; and

(iii) is not being paid a disability support pension under the Social Security Act 1991; and

(iv) is wholly or substantially dependent on the person or on the spouse of the person.

GN.14.34 Principles of interpretation of the MBS

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

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

GN.14.35 Services attracting benefits on an attendance basis

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

GN.14.36 Consultation and procedures rendered at the one attendance

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

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

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

GN.14.37 Aggregate items

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

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

GN.14.38 Residential aged care facility

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

GN.15.39 Practitioners should maintain adequate and contemporaneous records

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

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

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

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

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

clearly identify the name of the patient; and

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

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

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

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

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

CATEGORY 3: THERAPEUTIC PROCEDURES

SUMMARY OF CHANGES FROM 01/03/2021

The 01/03/2021 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

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

Deleted Items

30696 30710 41889 41892 41895 41898 41901 41905

New Items

38416 38417 38419 38420 38422 38423 38425 38426 45658

Description Amended

15900 22060 30196 30202 31516 32223 32224 32226 35570 35571 35573 35577 35581 35582 35585 42739

Fee Amended

22060 30630

New item for correction of congenital deformity of the ear

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

Amendment to Targeted Intraoperative Radiotherapy Item 15900 and 31516

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

Fee change to item 30630 to reflect MBS review recommendation

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

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

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

Cardio Thoracic

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

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

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

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

THERAPEUTIC PROCEDURES NOTES

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

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

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

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

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

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

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

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

(c) is staffed by:

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

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

(d) has admission and discharge policies in operation.

TN.1.2 Haemodialysis - (Items 13100 and 13103)

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

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

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

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

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

(generally monthly);

- Feed-back of results to the home patient and his or her treating general physician;

- Adjustments to medications and dialysis therapies based upon these results;

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

- Referral to, and communication with, other specialists involved in the care of the patient; and

- Being available to advise the patient or the patient's agent.

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

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

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

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

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

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

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

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

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

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

TN.1.5 Intracytoplasmic Sperm Injection - (Item 13251)

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

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

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

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

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

TN.1.6 Peripherally Inserted Central Catheters

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

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

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

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

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

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

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

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

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

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

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

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

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

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

(c) has defined admission and discharge policies.

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

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

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

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

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

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

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

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

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

(c) has defined admission and discharge policies.

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

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

(i) all babies weighing less than 1000gms;

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

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

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

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

(vi) all babies having frequent seizures.

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

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

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

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

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

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

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

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

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

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

Item 13839

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

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

Item 13842

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

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

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

Item 13848

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

Items 13851 and 13854

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

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

Item 13857

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

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

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

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

Items 13870 and 13873

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

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

Item 13876

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

Item 11600

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

Item 13899

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

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

Notes:

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

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

(a) the patient either:

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

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

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

(c) either:

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

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

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

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

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

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

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

(i) members of the patient's family;

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

(iii) other health practitioners;

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

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

(g) recording the agreed goals so that:

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

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

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

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

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

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

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

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

TN.1.12 Cytotoxic Chemotherapy Administration - (Item 13950)

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

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

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

Phototherapy should only be used when:

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

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

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

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

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

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

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

Entire forehead	50 -75 cm^2
Cheek	55 - 85 cm^2
Nose	10 -25 cm^2
Chin	10 - 30 cm^2
Unilateral midline anterior - posterior neck	60 - 220 cm^2
Dorsum of hand	25 - 80 cm^2
Forearm	100 - 250 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 the Department of Human Services CEO to participate in the arrangements made, under paragraph 100 (1) (b) of the National Health Act 1953, for the purpose of providing an adequate pharmaceutical service for persons requiring treatment with an immunomodulating agent.

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

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

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

(a) A medical practitioner, or;

(b) A specialist trainee under the direct supervision of a medical practitioner.

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

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

TN.1.21 Telehealth Specialist Services

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

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

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

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

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

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

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

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

TN.1.22 Cryopreservation of semen (Item 13260)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Management of Fractures (Items 14270 and 14272)

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

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

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

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

Chemical or Physical Restraints (Items 14277 and 14278)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Intent

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

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

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

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

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

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

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

intravascular;
intramuscular;
subcutaneous;
intrathecal; and
intracavitary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.2.1 Radiation Oncology - General

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

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

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

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

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

In items 15275, 15555, 15565 and 15715:

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

In item 15275:

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

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

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

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

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

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

A planning episode involves field setting and dosimetry. One plan only will attract Medicare benefits in a course of treatment. However, benefits are payable for further planning items where planning is undertaken in respect of a different tumour site to that (or those) specified in the original prescription by the radiation oncologist. Benefits are also payable for more than one plan when a plan for brachytherapy and a plan for megavoltage or teletherapy treatment are rendered in the same course of treatment.

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

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

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

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

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

In these items, 'treatment verification' means:

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

(a) x-rays (this includes portal imaging, either megavoltage or kilovoltage, using a linear accelerator)

(b) computed tomography; or

(c) ultrasound, where the ultrasound equipment is capable of producing images in at least three dimensions (unidimensional ultrasound is not covered); together with a record of the assessment(s) and any correction(s) of significant treatment delivery inaccuracies detected.

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

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

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

Items 15700, 15705, 15710 and 15715:

- may not claimed together for the same attendance at which treatment is rendered

- must only be itemised when the verification procedure has been prescribed in the treatment plan and the image has been reviewed by a radiation oncologist

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Item 16400 can only be claimed 10 times per pregnancy.

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

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

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

TN.4.3 Antenatal Care - (Item 16500)

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

(a) Items 16501, 16502, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514, 16533, 16534 and 16600 to 16627.

(b) The initial consultation at which pregnancy is diagnosed.

(c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.

(d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.

(e) Treatment of an intercurrent condition not directly related to the pregnancy.

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

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

Contraindications for this item are as follows:

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

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

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

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

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

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

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

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

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

TN.4.6 Caesarean Section - (Item 16520)

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

TN.4.7 Complicated Confinement - (Item 16522)

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

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

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

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

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

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

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

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

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

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

(i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;

(ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);

(iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals

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

(iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;

(v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

Normal postnatal care by a medical practitioner would include:-

(i) uncomplicated care and check of

- lochia
- fundus
- perineum and vulva/episiotomy site
- temperature
- bladder/urination
- bowels

(ii) advice and support for establishment of breast feeding

(iii) psychological assessment and support

(iv) Rhesus status

(v) Rubella status and immunisation

(vi) contraception advice/management

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

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

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

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

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

TN.4.12 Telehealth Specialist Services

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

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

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

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

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

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

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

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

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

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

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

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

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

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

COVID-19 MBS telehealth and phone attendance items by obstetricians, general practitioners, midwives, nurse and Aboriginal and Torres Strait Islander health practitioners (ceases on 30 September 2020 unless revoked earlier).

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

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

COVID-19 – TEMPORARY MBS TELEHEALTH ITEMS

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

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

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

supervision of, a medical practitioner			
Postnatal attendance by an obstetrician or GP	16407	91851	91856
Postnatal attendance by: (i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner	16408	91852	91857
Antenatal attendance	16500	91853	91858

Further information related to services rendered by an obstetrician/general practitioner/midwife/nurse or Aboriginal and Torres Strait Islander health practitioner can be found in the 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 eg free flap transfers, breast reconstruction

· major joint arthroplasty

· joint reconstruction

· Thoracotomy

· Craniotomy

· Spinal surgery eg spinal fusion, discectomy

· Major vascular surgery eg aortic aneurysm repair, arterial bypass surgery, carotid artery endarterectomy

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

· Major cardiac problems - e.g cardiomyopathy, unstable ischaemic heart disease, heart failure

· Major respiratory disease - e.g COPD, respiratory failure, acute lung conditions eg. infection and asthma,

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

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

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

· Other conditions -

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

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

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

NOTE I:

It is important to note that:

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

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

NOTE II:

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

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

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

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

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

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

(i) Acute pain management

· Postoperative, utilising specialised techniques eg Patient Controlled Analgesia System (PCAS)

· as an independent service eg pain control following fractured ribs requiring nerve blocks

· obstetric pain management

(ii) Perioperative management of patients

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

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

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

NOTE :

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

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

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

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

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

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

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

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

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

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

TN.6.4 Telehealth Specialist Services

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

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

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

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

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

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

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

TN.7.1 Regional or Field Nerve Blocks - General

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

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

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

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

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

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

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

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

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

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

This items covers caudal infusion/injection.

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

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

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

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

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

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

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

TN.8.1 Surgical Operations

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

· "as an independent procedure";

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

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

An explanation of each of these phrases is as follows.

As an Independent Procedure

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

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

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

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

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

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

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

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

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

TN.8.2 Multiple Operation Rule

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

- 100% for the item with the greatest Schedule fee

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

plus 25% for each other item.

Note:

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

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

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

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

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

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

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

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

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

Extended Medicare Safety Net Cap

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

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

TN.8.3 Procedure Performed with Local Infiltration or Digital Block

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

TN.8.4 Aftercare (Post-operative Treatment)

Definition

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

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

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

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

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

Private Patients

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

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

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

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

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

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

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

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

Public Patients

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

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

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

Fractures

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

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

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

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

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

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

TN.8.5 Abandoned surgery - (Item 30001)

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

An operative procedure commences when:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.8.8 Lipectomy - (Items 30165 to 30179)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Services Australia (SA) has developed a Health Practitioner Guideline to substantiate proof of malignancy where required for MBS items which is located on the SA website.

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

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

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

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

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

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

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

Anatomically, the dissection extends from below upwards as follows:

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

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

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

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

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

TN.8.16 Major Abdominal Incision - (Item 30396)

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

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

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

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

Cleaning, disinfection and sterilisation procedures

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

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

Anaesthetic and resuscitation equipment

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

Conjoint Committee

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

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

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

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

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

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

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

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

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

For the purposes of these items the following definitions apply:

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

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

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

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

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

- A patient with biochemical evidence of a neuroendocrine tumour.

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

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

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

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

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

Items 31357, 31360, 31362, 31364, 31366, 31368, 31370 *require* that the specimen be sent for histological examination. Items 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371-31376 also *require* that a specimen has been sent for histological confirmation of malignancy, and any subsequent specimens are sent for

histological examination. Confirmation of malignancy *must* be received before itemisation of accounts for Medicare benefits purposes.

Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation. If the histological report shows the lesion to be benign, items 31357, 31360, 31362, 31364, 31366, 31368 or 31370 should be used.

It will be necessary for practitioners to retain copies of histological reports.

TN.8.23 Removal of Skin Lesion From Face - (Items 31245, 31361 to 31364, 31372 and 31373)

For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

TN.8.24 Dissection of Lymph Nodes of Neck - (Items 30618, 31423 to 31438)

For the purposes of these items, the lymph node levels referred to are as follows:

Level I	Submandibular and submental lymph nodes
Level II	Lymph nodes of the upper aspect of the neck including the jugulodigastric node, upper jugular chain nodes and upper spinal accessory nodes
Level III	Lymph nodes deep to the middle third of the sternomastoid muscle consisting of mid jugular chain nodes, the lower most of which is the jugulo-omohyoid node, lying at the level where the omohyoid muscle crosses the internal jugular vein
Level IV	Lower jugular chain nodes, including those nodes overlying the scalenus anterior muscle
Level V	Posterior triangle nodes, which are usually distributed along the spinal accessory nerve in the posterior triangle

Comprehensive dissection involves all 5 neck levels while ***selective*** dissection involves the removal of only certain lymph node groups, for example:-

Item 31426 (removal of 3 lymph node levels) - e.g. supraomohyoid neck dissection (levels I-III) or lateral neck dissection (levels II-IV).

Item 31429 (removal of 4 lymph node levels) - e.g. posterolateral neck dissection (levels II-V) or anterolateral neck dissection (levels I-IV)

Other combinations of node levels may be removed according to clinical circumstances.

TN.8.25 Excision of Breast Lesions, Abnormalities or Tumours - Malignant or Benign - (Items 31500 to 31515)

Therapeutic biopsy or excision of breast lesions, abnormalities or tumours under Items: 31500, 31503, 31506, 31509, 31512, 31515 either singularly or in combination should not be claimed when using the Advanced Breast Biopsy Instrumentation (ABBI) procedure, or any other large core breast biopsy device.

TN.8.26 Breast Biopsy Items – items 31533 (Fine Needle Aspiration) and 31548 (Mechanical Device Biopsy)

Breast abnormalities requiring biopsy should be assessed by core biopsy or vacuum-assisted core biopsy. If a service has access to high-quality cytology with immediate reporting, then fine needle aspiration (FNA) may be used in addition to mechanical device biopsy, but not instead of it. In exceptional cases, based on a clinician's judgement, FNA may be used alone if mechanical device biopsy is not possible.

In relation to item 31533 (FNA) an impalpable lesion includes those lesions that clinically require definition by ultrasound or mammography for accurate or safe sampling, eg. lesions in association with breast prostheses or in areas of breast thickening.

TN.8.27 Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation - (Items 31539 and 31545)

For the purposes of Items 31539 and 31545, surgeons performing this procedure should have evidence of appropriate training via a course approved by the Breast Section of the Royal Australasian College of Surgeons, have experience in the procedure, and the Department of Human Services notified of their eligibility to perform this procedure.

The ABBI procedure is contraindicated and should not be performed on the following subset of patients:

- Patients with mass, asymmetry or clustered microcalcifications that cannot be targeted using digital imaging equipment;
- Patients unable to lie prone and still for 30 to 60 minutes;
- Breasts less than 20mm in thickness when compressed;
- Women on anticoagulants;
- Lesions that are too close to the chest wall to allow cannula access;
- Patients weighing more than 135kg;
- Women with prosthetic breast implants.

TN.8.28 Preoperative Localisation of Breast Lesion Prior to the Use of Advanced Breast Biopsy Instrumentation - (Item 31542)

For the purposes of item 31542, radiologists eligible to perform the procedure must have been identified by the Royal Australian and New Zealand College of Radiologists as having sufficient training and experience in this procedure, and the Department of Human Services notified of their eligibility to perform this procedure.

TN.8.29 Bariatric Procedures - (Items 31569 to 31581, anaesthesia item 20791)

Items 31569 to 31581 and item 20791 provide for surgical treatment of clinically severe obesity and the accompanying anaesthesia service (or similar). The term clinically severe obesity generally refers to a patient with a Body Mass Index (BMI) of 40kg/m^2 or more, or a patient with a BMI of 35kg/m^2 or more with other major medical co-morbidities (such as diabetes, cardiovascular disease, cancer). The BMI values in different population groups may vary due, in part, to different body proportions which affect the percentage of body fat and body fat distribution. Consequently, different ethnic groups may experience major health risks at a BMI that is below the 35-40 kg/m^2 provided for in the definition. The decision to undertake obesity surgery remains a matter for the clinical judgment of the surgeon.

If crural repair taking 45 minutes or less is performed in association with the bariatric procedure, additional hernia repair items cannot be claimed for the same service.

TN.8.30 Reversal of a Bariatric Procedure (item 31584)

If a revisional procedure requires the reversal of the existing bariatric procedure, item 31584 can be claimed with items 31569 to 31581 for the new procedure for the same patient on the same occasion. For example, item 31584

could be claimed for the reversal of a gastric band, and 31572 for conversion to gastric bypass or 31575 for conversion to sleeve gastrectomy.

TN.8.31 Per Anal Excision of Rectal Tumour using Rectoscopy - (Items 32103, 32104 and 32106)

Surgeons performing these procedures should be colorectal surgeons and have undergone appropriate training which is recognised by the Colorectal Surgical Society of Australasia.

Items 32103, 32104 and 32106 cannot be claimed in conjunction with each other or with anterior resection items 32024 or 32025 for the same patient, on the same day, by any practitioner.

TN.8.32 Varicose veins (Items 32500 to 32517) and Peripheral Arterial or Venous Embolisation (Item 35321)

Under the *Health Insurance (General Medical Services Table) Regulations*, items 32500 to 32517 and 35321 do not apply to services mentioned in those items if the services are delivered by:

a. endovenous laser treatment (ELT); or
b. radiofrequency diathermy; or
c. radiofrequency ablation for varicose veins.

It is recommended that a practitioner who intends to bill ELT, radiofrequency diathermy or radiofrequency ablation for varicose veins on the same occasion as providing items 32500 to 32517 or 35321 contact the Department of Human Services' provider information line on 132 150 to confirm requirements for correct itemisation of services on a single invoice.

The Department of Health monitors billing practices associated with MBS items. Services for ELT, radiofrequency diathermy or radiofrequency ablation for varicose veins provided on the same occasion as items 32500 to 32517 or 35321 must be itemised separately on the invoice, showing the full fees for each service separately to the fees billed against these MBS items.

TN.8.33 Cyanoacrylate Embolisation (Items 32528 and 32529), Endovenous Laser Therapy (Items 32520 and 32522) and Radiofrequency Ablation (Items 32523 and 32526)

It is recommended that the medical practitioner performing cyanoacrylate embolisation (CAE), endovenous laser therapy (ELT) or radiofrequency ablation (RFA) has successfully completed a substantial course of study and training in the management of venous disease, which has been endorsed by their relevant professional organisation.

Medicare-funded CAE, ELT and RFA can only be performed in cases where it is documented by duplex ultrasound that the great or small saphenous vein (and major tributaries of saphenous veins as necessary) demonstrates reflux of 0.5 seconds or longer.

TN.8.34 Uterine Artery Embolisation - (Item 35410)

This item was introduced on an interim basis in November 2006 following a recommendation of the Medical Services Advisory Committee (MSAC), pending the outcome of clinical trials and further consideration by the MSAC. The requirement for specialist referral by a gynaecologist for uterine artery embolisation was a MSAC recommendation. Providers should retain the instrument of specialist referral for each patient from the date of the procedure, as this may be subject to audit by the Department of Human Services.

TN.8.35 Endovascular Coiling of Intracranial Aneurysms - (Item 35412)

This service includes balloon angioplasty and insertion of stents (assisted coiling) associated with intracranial aneurysm coiling. The use of liquid embolics alone is not covered by this item. Digital Subtraction Angiography (DSA) done to diagnose the aneurysm (items 60009 and either 60072, 60075 or 60078) is claimable, however this must be clearly noted on the claim and in the clinical notes as separate from the intra-operative DSA done with the coiling procedure.

TN.8.36 Arterial and Venous Patches - (Items 33545 to 33551and 34815)

Vascular surgery items have been constructed on the basis that arteriotomy and venotomy wounds are closed by simple suture without the use of a patch.

Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct item would be 34815 or 34518. If the vein is harvested for the patch through a separate incision, Item 33551 would also apply, in accordance with the multiple operation rule.

If a patch graft is involved in conjunction with an operative procedure included in Items 33500 - 33542, 33803, 33806, 33815, 33833 or 34142, the patch graft would attract benefits under Item 33545 or 33548 in addition to the item for the primary operation (under the multiple operation rule). Where vein is harvested for the patch through a separate incision Item 33551 would also apply.

TN.8.37 Carotid Disease - (Item 32700, 32703, 32760, 33500, 33545, 33548, 33551, 33554, 35303, 35307)

Interventional procedures for the management of carotid disease should be performed in accordance with the NHMRC endorsed *Clinical Guidelines for Stroke Management 2010*.

Carotid Percutaneous Transluminal Angioplasty with Stenting (CPTAS), under item 35307 is only funded under the MBS for patients who meet the criteria for carotid endarterectomy but are unfit for open surgery.

TN.8.38 Peripheral Arterial or Venous Catheterisation - (Item 35317)

Item 35317 is restricted to the regional delivery of thrombolytic, vasoactive or chemotherapeutic oncologic agents in association with a radiological service. This item in not intended for infusions with systemic affect.

TN.8.40 Selective Internal Radiation Therapy (SIRT) using SIR-Spheres - (Items 35404, 35406 and 35408)

These items were introduced into the Schedule on an interim basis in May 2006 following a recommendation of the Medical Services Advisory Committee (MSAC) pending the outcome of clinical trials and further consideration by the MSAC. SIRT should not be performed in an outpatient or day patient setting to ensure patient and radiation safety requirements are met.

TN.8.41 Percutaneous Transluminal Coronary Angioplasty - (Items 38309, 38312, 38315 and 38318)

A coronary artery lesion is considered to be complex when the lesion is a chronic total occlusion, located at an ostial site, angulated, tortuous or greater than 1cm in length. Percutaneous transluminal coronary rotational atherectomy is suitable for revascularisation of complex and heavily calcified coronary artery stenoses in patients for whom coronary artery bypass graft surgery is contraindicated.

Each of the items 38309, 38312, 38315 and 38318 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

TN.8.42 Colposcopic Examination - (Item 35614)

It should be noted that colposcopic examination (screening) of a person during the course of a consultation does not attract Medicare benefits under Item 35614 except in the following circumstances:

(a) where the patient has had an abnormal cervical screen result;

(b) where there is a history of ingestion of oestrogen by the patient's mother during their pregnancy; or

(c) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

TN.8.43 Hysteroscopy - (Item 35626)

Hysteroscopy undertaken in the office/consulting rooms can be claimed under this item where the conditions set out in the description of the item are met.

TN.8.44 Curettage of Uterus under GA or Major Nerve Block - (Items 35639 and 35640)

Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract benefits under these items but would be paid under Item 35620 where malignancy is suspected, or otherwise on an attendance basis.

TN.8.45 Neoplastic Changes of the Cervix - (Items 35644-35648)

The term "previously confirmed intraepithelial neoplastic changes of the cervix" in these items refers to diagnosis made by either cytologic, colposcopic or histologic methods. This may also include persistent human papilloma virus (HPV) changes of the cervix.

TN.8.46 Sterilisation of Minors - Legal Requirements - (Items 35657, 35687, 35688, 35691, 37622 and 37623)

(i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.

(ii) Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.

(iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures. Medicare Benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the *Health Insurance Act 1973.*

TN.8.47 Debulking of Uterus - (Item 35658)

Benefits are payable under Item 35658, using the multiple operation rule, in addition to vaginal hysterectomy.

TN.8.50 Sacral Nerve Stimulation (items 36663-36668)

A two-stage process of testing and treatment is required to ensure suitability for Sacral Nerve Stimulation for detrusor overactivity or non obstructive urinary retention where urethral obstruction has been urodynamically excluded. The testing phase involves acute and sub-chronic testing. The first stage includes peripheral nerve evaluation and patients who achieve greater than 50% improvement in urinary incontinence or retention episodes during testing will be eligible to receive permanent SNS treatment.

TN.8.51 Ureteroscopy - (Item 36803)

Item 36803 refers to ureteroscopy of one ureter when performed for the purpose of inspection alone. It may not be used when one of the other ureteroscopy numbers (Items 36806 or 36809) or pyeloscopy numbers (Items 36652, 36654 or 36656) is used for a ureteroscopic procedure performed in the same ureter or collecting system. It may be used when inspection alone is carried out in one ureter independently from a ureteroscopic or pyeloscopic procedure in another ureter or collecting system. If Item number 36803 is used with one of the other above 5 numbers, it must be specified that item number 36803 refers to ureteroscopy performed in another ureter eg 36654 (Right side) and 36803 (Left side). 36803 may also be used in this way if there is a partial or complete duplex collecting system eg 36809 (Lower pole moiety ureter, Left side) and 36803 (Upper pole moiety ureter, Left side).

Item numbers 36806 and 36809 may only be used together when 2 independent ureteroscopic procedures are performed in separate ureters. These separate ureters may be components of a complete or partial duplex system. If both these numbers are used together, the Regulations require qualification of these item numbers by the site, as is necessary with 36803 eg 36806 (Right side) and 36809 (Left side).

TN.8.52 Selective Coronary Angiography - (Items 38215 to 38246)

Each item in the range 38215-38240 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

Item 38243 may be billed once only immediately prior to any coronary interventional procedure, including situations where a second operator performs any coronary interventional procedure after diagnostic angiography by the first operator.

Item 38246 may be billed when the same operator performs diagnostic coronary angiography and then proceeds directly with any coronary interventional procedure during the same occasion of service. Consequently, it may not be billed in conjunction with items 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243. In the event that the same operator performed any coronary interventional procedure immediately after the diagnostic procedure described by item 38231, 38237 or 38240, that item may be billed as an alternative to item 38246.

Items in the range 38215 - 38246 cannot be claimed for any intravascular ultrasound (IVUS) procedure therefore Medicare Benefits are not payable for IVUS.

TN.8.53 Transurethral Needle Ablation (TUNA) of the Prostate - (Items 37201 and 37202)

Moderate to severe lower urinary tract symptoms are defined using the American Urological Association (AUA) Symptom Score or the International Prostate Symptom Score (IPSS).

Patients not medically fit for transurethral resection of the prostate (TURP) can be defined as:

(i) Those patients who have a high risk of developing a serious complication from the surgery. Retrograde ejaculation is **not** considered to be a serious complication of TURP.

(ii) Those patients with a co-morbidity which may substantially increase the risk of TURP or the risk of the anaesthetic necessary for TURP.

TN.8.54 Fiducial Markers into the Prostate - (Item 37217)

Item 37217 is for the insertion of fiducial markers into the prostate or prostate surgical bed as markers for radiotherapy. The service can not be claimed under item 37218 or any other surgical item.

This item is introduced into the Schedule on an interim basis pending the outcome of an evaluation being undertaken by the Medical Services Advisory Committee (MSAC).

Further information on the review of this service is available from the MSAC Secretariat.

TN.8.55 Brachytherapy of the Prostate - (Item 37220)

One of the requirements of item 37220 is that patients have a Gleason score of less than or equal to 7 (Grade Group 1-3). However, where the patient has a score of 7, comprising a primary score of 4 and a secondary score of 3 (ie. 4+3=7; Grade Group 3), it is recommended that low dose rate brachytherapy form part of a combined modality treatment.

Low dose rate brachytherapy of the prostate should be performed in patients, with favourable anatomy allowing adequate access to the prostate without pubic arch interference, and who have a life expectancy of greater than 10 years.

An 'approved site' for the purposes of this item is one at which radiation oncology services may be performed lawfully under the law of the State or Territory in which the site is located.

TN.8.56 High Dose Rate Brachytherapy - (Item 37227)

Item 37227 covers the service undertaken by an urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. If the service is undertaken by an urologist, a radiation oncologist must be present in person at the time of the service. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

TN.8.57 Radical or Debulking Operation for Ovarian Tumour - (Item 35720)

This item refers to the operation for carcinoma of the ovary where the bulk of the tumour and the omentum are removed. Where this procedure is undertaken in association with hysterectomy benefits are payable under both item numbers with the application of the multiple operation formula.

TN.8.58 Transcutaneous Sperm Retrieval - (Item 37605)

Item 37605 covers transcutaneous sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies.

Item 37605 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply, in accordance with point T8.5 of these Explanatory Notes.

Where the procedure is carried out under local infiltration as the means of anaesthesia, additional benefit is not payable for the anaesthesia component as this is considered to be part of the procedure.

TN.8.59 Surgical Sperm Retrieval, by Open Approach - (Item 37606)

Item 37606 covers open sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies. Item 37606 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply.

Benefits for item 37606 may be claimed in conjunction with a service or services provided under item 37605, where an open approach is clinically necessary following an unsuccessful percutaneous approach. Likewise, such services would be subject to the multiple operation rule.

Benefit is not payable for item 37606 in conjunction with item 37604.

TN.8.60 Cardiac Pacemaker Insertion - (Items 38209, 38212, 38350, 38353 and 38356)

The fees for the insertion of a pacemaker (Items 38350, 38353 and 38356) cover the testing of cardiac conduction or conduction threshold, etc related to the pacemaker and pacemaker function.

Accordingly, additional benefits are not payable for such routine testing under Item 38209 or 38212 (Cardiac electrophysiological studies).

TN.8.61 Implantable ECG Loop Recorder - (Item 38285)

The fee for implantation of the loop recorder (item 38285) covers the initial programming and testing of the device for satisfactory rhythm capture. Benefits are payable only once per day.

The term "recurrent" refers to more than one episode of syncope, where events occur at intervals of 1 week or longer. The term "other available cardiac investigations" includes the following:

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;
- *electrocardiography (ECG) (items 1170-11702);*
- *echocardiography (items 55113-55115);*
- *continuous ECG recording or ambulatory ECG monitoring (items 11708-11711);*
- *up-right tilt table test (item 11724); and*
- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

TN.8.62 Transluminal Insertion of Stent or Stents - (Item 38306)

Item 38306 should only be billed once per occlusional site. It is not appropriate to bill item 38306 multiple times for the insertion of more than one stent at the same occlusional site in the same artery. However, it would be appropriate to claim this item multiple times for insertion of stents into the same artery at different occlusional sites or into another artery or occlusional site. It is expected that the practitioner will note the details of the artery or site into which the stents were placed, in order for the Department of Human Services to process the claims.

TN.8.63 Permanent Cardiac Synchronisation Device (Items 38365, 38368 and 38654)

Items 38365, 38368 and 38654 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had a CRT device and transvenous left ventricular electrode inserted and who prior to its insertion met the criteria and now need the device replaced.

TN.8.64 Intravascular Extraction of Permanent Pacing Leads - (Item 38358)

For the purposes of Item 38358 specialists or consultant physicians claiming this item must have training recognised by the Lead Extraction Advisory Committee of the Cardiac Society of Australia and New Zealand, and the Department of Human Services notified of that recognition. The procedure should only be undertaken in a hospital capable of providing cardiac surgery.

TN.8.65 Cardiac Resynchronisation Therapy - (Item 38371)

Item 38371 applies only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had an CRT device capable of defibrillation inserted and who prior to its insertion met the criteria and now need the device replaced.

TN.8.66 Implantable Cardioverter Defibrillator - (Items 38384 and 38387)

Items 38384 and 38387 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had an ICD device inserted and who prior to its insertion met the criteria and now need the device replaced.

TN.8.67 Cardiac and Thoracic Surgical Items - (Items 38470 to 38766)

Items 38470 to 38766 must be performed using open exposure or minimally invasive surgery which excludes percutaneous and transcatheter techniques unless otherwise stated in the item.

TN.8.68 Coronary Artery Bypass - (Items 38497 to 38504)

The fees for Items 38497 and 38498 include the harvesting of vein graft material. Harvesting of internal mammary artery and/or vein graft material is covered in the fees for Items 38500, 38501, 38503 and 38504. Where harvesting of an artery other than the internal mammary artery is undertaken, benefits are payable under Item 38496 on the multiple operation basis. The procedure of coronary artery bypass grafting using arterial graft is covered by Item 38500, 38501, 38503 or 38504 irrespective of the origin of the arterial graft.

Items 38498, 38501 and 38504 require that either a clinical or medical perfusionist are present in the operating theatre throughout the procedure in case it is necessary to convert to an on-pump procedure and cardiopulmonary bypass is required.

If it is necessary to provide cardiopulmonary bypass items 38498, 38501 and 38504 cannot be claimed. The procedure should be claimed under items 38497, 38500 or 38503 as appropriate in conjunction with the relevant cardiopulmonary bypass procedures.

TN.8.69 Re-operation via Median Sternotomy - (Item 38640)

Medicare benefits are payable for Item 38640 plus the item/s covering the major surgical procedure/s performed at the time of the re-operation, using the multiple operation formula. Benefits are not payable for Item 38640 in association with Item 38656, 38643 or 38647.

TN.8.70 Skull Base Surgery - (Items 39638 to 39656)

The surgical management of lesions involving the skull base (base of anterior, middle and posterior fossae) often requires the skills of several surgeons or a number of surgeons from different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of the dura, subcutaneous tissues, and skin to avoid serious infections such as osteomyelitis and/or meningitis.

Items 39638 to 39656 cover the removal of the tumour, which would normally be performed by a neurosurgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as ENT and plastic and reconstructive surgery.

TN.8.71 Intradiscal Injection of Chymopapain - (Item 40336)

The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

TN.8.72 Removal of Ventilating Tube from Ear - (Item 41500)

Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.

TN.8.73 Meatoplasty - (Item 41515)

When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

TN.8.74 Reconstruction of Auditory Canal - (Item 41524)

When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

TN.8.75 Removal of Nasal Polyp or Polypi - (Items 41662 and 41668)

Where such polyps are removed in association with another intranasal procedure, Medicare benefit is paid under Item 41662. However where the associated procedure is of lesser value than Item 41668, benefit for removal of polypi would be paid under Item 41668.

Services performed under item 41668 require admission to hospital.

TN.8.76 Larynx, Direct Examination - (Item 41501)

Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

TN.8.77 Microlaryngoscopy - (Item 41858)

This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

TN.8.78 Imbedded Foreign Body - (Item 42644)

For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.

Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.

Where the imbedded foreign body is not completely removed, benefits are payable under the relevant attendance item.

TN.8.79 Corneal Incisions - (Item 42672)

The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

TN.8.80 Cataract surgery (Items 42698 and 42701)
Items 42698 and 42701 provide for intraocular lens extraction and replacement as a separate procedure to be used in instances when lens removal and replacements are contraindicated at the same operation, such as in patients presenting with proliferative diabetic retinopathy or recurrent uveitis.

TN.8.81 Posterior Juxtascleral Depot injection - (Item 42741)
For the purpose of item 42741, the therapeutic substance must be registered with the Therapeutic Goods Administration (or listed on the Pharmaceutical Benefits Schedule, if so listed) as being suitable for injection for the treatment of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation due to age-related macular degeneration, as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60.

TN.8.82 Cyclodestructive Procedures - (Items 42770)
Item 42770 is restricted to a maximum of 2 treatments in a 2 year period.

TN.8.83 Insertion of drainage device for glaucoma (Item 42752)
Item 42752 provides for the insertion of a drainage device for the treatment of glaucoma patients who are at high risk of failure of trabeculectomy (such as patients who have aggressive neovascular glaucoma or extensive conjunctival scarring); have iridocorneal endothelial syndrome; inflammatory (uveitic) glaucoma; or aphakic glaucoma.

TN.8.84 Laser Trabeculoplasty - (Item 42782)
Item 42782 is restricted to a maximum of 4 treatments in a 2 year period.

TN.8.85 Laser Iridotomy - (Item 42785)
Item 42785 is restricted to a maximum of 3 treatments in a 2 year period.

TN.8.86 Laser Capsulotomy - (Items 42788)
Item 42788 is restricted to a maximum of 2 treatments in a 2 year period.

TN.8.87 Laser Vitreolysis or Corticolysis of Lens Material or Fibrinolysis - (Item 42791)
Item 42791 is restricted to a maximum of 3 treatments in a 2 year period.

TN.8.88 Division of Suture by Laser - (Item 42794)
Benefits under this item are restricted to a maximum of 2 treatments in a 2 year period. There is no provision for additional treatments in that period.

TN.8.89 Ophthalmic Sutures - (Item 42845)

This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning, or adjustment performed prior to the patient leaving the operating theatre.

TN.8.91 Abrasive Therapy/Resurfacing - (Items 45021 to 45026)

For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

Items 45021 and 45024 cover abrasive therapy only. For the purposes of these items, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for benefits under these items.

Items 45025 and 45026 do not cover the use of fractional (Fraxel®) laser therapy.

TN.8.92 Escharotomy - (Item 45054)

Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

TN.8.93 Local Skin Flap - Definition

Medicare benefits for flaps are only payable when clinically appropriate. Clinically appropriate in this instance means that the flap or graft is required to close the defect because the defect cannot be closed directly, or because the flap is required to adapt scar position optimally with regard to skin creases or landmarks,maintain contour on the face or neck, or prevent distortion of adjacent structures or apertures.

A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Item 45201, claimable once per defect. Additional flaps are to be claimed under Item 45202, if clinically indicated.

Note: refer to TN.8.126 for MBS item 45202 for circumstances where other services might involve flap repair.

TN.8.94 Free Grafting to Burns - (Items 45406 to 45418)

Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

TN.8.95 Revision of Scar - (Items 45506 to 45518)

For the purposes of items 45506 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape of facial aperture.

Items 45506 to 45518 are only claimable when performed by a specialist in the practice of his or her specialty or where undertaken in the operating theatre of a hospital.

Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31206 to 31225 should be claimed.

TN.8.96 Augmentation Mammaplasty - (Items 45524, 45527 and 45528)

A Medicare benefit is generally not attracted under item 45524 unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast sometime after an initial augmentation of one side would not attract benefits. Benefits are not payable for augmentation mammaplasty services performed using fat transfer to the breast.

Item 45528 applies where bilateral mammaplasty is indicated because of malformation of breast tissue, disease or trauma of the breast, (but not as a result of previous cosmetic surgery) other than covered under item 45524 or 45527.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

TN.8.97 Breast Reconstruction, Myocutaneous Flap - (Item 45530)

When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a rectus abdominis flap; item 45569 should be claimed for closure of the abdomen and reconstruction of the umbilicus, and item 45570 may be claimed if repair of the musculoaponeurotic layer is required. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be claimed as it is expected that repair will be by direct suture. In the small number of cases, when a latissimus dorsi flap is used, and repair by means other than direct suture is required, use of item 45203 would be appropriate.

Items 30165-30179 (lipectomy items) should not be claimed in association with item 45530 as stated in the Health Insurance (General Medical Services Table) Regulations.

TN.8.98 Breast Prosthesis, Removal and Replacement of - (Items 45553 and 45554)

It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Medicare benefits are not payable for services under items 45553-45554 where the procedure is performed solely to increase breast size.

Where the original implant was not inserted in the context of breast cancer or developmental abnormality, intra-operative photographs of the patient in the supine position need to demonstrate unacceptable deformity in the form of a discreet concavity to justify use of 45553 or 45554.

In the context of eligibility for item 45553 and 45554, an unacceptable deformity would not include asymmetry caused as a result of removal of one implant out of a pair of implants.

Where a rupture has been established through imaging and reported, items 45553 and 45554 will still apply even if intra-operatively the implant is found to be structurally intact.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.99 Breast Ptosis - (Items 45556 and 45558)

For the purposes of item 45556, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, in the context of breast cancer or developmental breast abnormality to match the position of the contralateral breast. This item is payable only once per patient. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

Item 45558 applies where correction of breast ptosis is indicated because at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mammary fold where the nipple is located at the most dependent, inferior part of the breast contour.

Full clinical details must be documented in patient notes, including pre-operative photographic evidence (including anterior, left lateral and right lateral views) as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

TN.8.100 Nipple and/or Areola Reconstruction - (Items 45545 and 45546)

Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

TN.8.101 Liposuction - (Items 45584 and 45585)

Medicare benefits for liposuction are generally attracted under item 45584, that is for the treatment of post-traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would benefits be payable for bilateral liposuction.

Where liposuction is indicated for the treatment of Barraquer-Simons Syndrome, lymphoedema or macrodystrophia lipomatosa, or the reduction of buffalo hump, item 45585 applies. One regional area is defined as one limb or trunk. If liposuction is required on more than one limb, item 45585 can be claimed once per limb.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.102 Meloplasty for Correction of Facial Asymmetry - (Items 45587 and 45588)

Benefits are payable under items 45587 and 45588 for face lift operations performed in hospital to correct soft tissue abnormalities of the face due to causes other than the ageing process, including trauma, a congenital condition or disease.

Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooling from the angles of the mouth and deep pitting of the skin resulting from severe acne scarring, disease or trauma (but not as a result of previous cosmetic surgery), item 45588 applies.

Full clinical details must be documented in patient notes, including pre-operative photographic and/or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.103 Reduction of Eyelids - (Items 45617 and 45620)

Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits.

Medicare benefits are not payable for non-therapeutic cosmetic services. Full clinical details must be documented in patient notes, including clear photographic evidence of the loss of visual field, evidenced by eyelid skin prolapsing over the lashes in a relaxed straight-ahead gaze. The clinical need for the service must be demonstrated as this may be subject to audit.

TN.8.104 Rhinoplasty - (Items 45632 to 45644, and 45650)

Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

A Medicare benefit for items 45632 – 45644 and 45650 is payable where the indication for surgery is for:

(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or

(ii) significant acquired, congenital or developmental deformity.

The NOSE Scale refers to the Nasal Obstruction Symptom Evaluation Scale, developed by Stewart et al, as published in the Otolaryngology-Head and Neck Surgery, 130: 2.

The NOSE Scale can be accessed here: https://www.entnet.org//content/facial-plasticsrhinology-outcome-tool-nose-scale

Full clinical details must be documented in patient notes, including pre-operative photographic and / or NOSE Scale evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.105 Contour Restoration - (Item 45647)

For the purpose of item 45647, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

TN.8.106 Vermilionectomy - (Item 45669)

Item 45669 covers treatment of the entire lip.

TN.8.107 Osteotomy of Jaw - (Items 45720 to 45752)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

For the purposes of these items, a reference to maxilla includes the zygoma.

Item 75621 for the provision of fitting of surgical templates may be claimed in association with the appropriate orthognathic surgical items in the range of 45720 to 45754 for prescribed dental patients registered under the Cleft Lip and Cleft Palate Scheme.

TN.8.108 Genioplasty - (Item 45761)

Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

TN.8.109 Tumour, Cyst, Ulcer or Scar - (Items 45801 to 45813)

It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

TN.8.110 Fracture of Mandible or Maxilla - (Items 45975 to 45996)

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

TN.8.111 Reduction of Dislocation or Fracture

Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

TN.8.112 Removal of Multiple Exostoses (Items 47933 and 47936)

Items 47933 and 47936 provide for removal of multiple exostoses when undertaken via the same incision.

TN.8.116 Wrist Surgery - (Items 49200 to 49227)

For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

TN.8.117 Diagnostic Arthroscopy and Arthroscopic Surgery of the Knee (Items 49557 and 49563)

The Medical Services Advisory Committee (MSAC) evaluated the available evidence and did not support public funding for matrix-induced autologous chondrocyte implantation (MACI) or autologous chondrocyte implantation

(ACI) for the treatment of chondral defects in the knee and other joints, due to the increased cost compared to existing procedures and the lack of evidence showing short term or long-term improvements in clinical outcomes. Medicare benefits are not payable in association with this technology.

TN.8.118 Paediatric Patients - (Items 50450 to 50658)

For the purpose of Medicare benefits a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state "with open growth plates").

TN.8.119 Treatment of Fractures in Paediatric Patients - (Items 50500 to 50588)

Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

Medicare benefits are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

TN.8.120 Unresectable primary malignant tumour of the liver destruction of by open or laparoscopic radiofrequency ablation or microwave tissue ablation- (Item 50952)

A multi-disciplinary team for the purposes of item 50952 would include a hepatobilliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

TN.8.121 Paracentesis of anterior chamber or vitreous cavity and/or intravitreal injection - (Items 42738 to 42740)

Items 42738 and 42739 provide for paracentesis for the injection of therapeutic substances and/or the removal of aqueous or vitreous, when undertaken as an independent procedure. That is, not in conjunction with other intraocular surgery.

Item 42739 should be claimed for patients requiring the administration of anaesthetic by an anaesthetist for the procedure. Advice from the Royal Australian and New Zealand College of Ophthalmologists is that independent injections require only topical anaesthesia, with or without subconjunctival anaesthesia, except in specific circumstances as outlined below where additional anaesthetic services may be indicated:

- nystagmus or eye movement disorder;

- cognitive impairment precluding safe intravitreal injection without sedation;

- a patient under the age of 18 years;

- a patient unable to tolerate intravitreal injection under local anaesthetic without sedation; or

- endophthalmitis or other inflammation requiring more extensive anaesthesia (eg peribulbar).

Practitioners billing item 42739 must keep clinical notes outlining the basis for the use of anaesthetic.

Item 42740 provides for intravitreal injection of therapeutic substances and/or the removal of vitreous for diagnostic purposes when performed in conjunction with other intraocular surgery including with a service to which Item 42809 (retinal photocoagulation) applies.

TN.8.122 Bone Graft (Items 48200-48242 and 48642-48651)

Bone graft substitute materials can be used for the purpose of bone graft for items 48200-48242 and 48642-48651.

TN.8.123 Vulvoplasty and Labioplasty - (Items 35533 and 35534)

Item 35533 is intended to cover the surgical repair of female genital mutilation or a major congenital anomaly of the uro-gynaecological tract which is not covered by existing MBS items. For example, this item would apply where a patient who has previously received treatment for cloacal extrophy, bladder exstrophy or congenital adrenal hyperplasia requires additional or follow-up treatment.

Item 35534 is intended to cover services for a structural abnormality causing significant functional impairment and is restricted to patients aged 18 years and over.

A detailed clinical history outlining the structural abnormality and the medical need for surgery of the vulva and/or labia must be included in patient notes, as this may be subject to audit.

Medicare benefits are not payable for non-therapeutic cosmetic services.

TN.8.124 Treatment of Wrist and Finger Fractures - (Items 47301 to 47319, and 47361 to 47373)

- For the purposes of these items, fixation includes internal and external.
- Regarding item 47362, major regional anaesthesia includes bier block.

TN.8.125 Removal of Skin Lesions - Necessary Excision Diameter - (Items 31356 to 31376)

The necessary excision diameter (or defect size) refers to the lesion size plus a clinically appropriate margin of healthy tissue required with the intent of complete surgical excision. Measurements should be taken prior to excision. Margin size should be determined in line with NHMRC guidelines:

Clinical practice guide - Basal cell carcinoma, squamous cell carcinoma(and related lesions)-a guide to clinical management in Australia. November 2008. Cancer Council Australia and; *Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand (2008).*

For the purpose of Items 31356 to 31376 the defect size is calculated by the average of the width and the length of the skin lesion and an appropriate margin. The necessary excision diameter is calculated as shown in the Factsheet at this link: Determining lesion size for MBS item selection.

Practitioners must retain copies of histological reports and any other supporting evidence (patient notes, photographs etc). Photographs should include scale.

An episode of care includes both the excision and closure for the same defect, even when excision and closure occur at separate attendances.

Definitive surgical excision for items 31371 to 31376 means surgical removal with adequate margins as part of the curative management of the malignancies specified in these items.

An incomplete surgical excision of a malignant skin lesion with curative intent should be billed as a malignant skin lesion excision item even when further surgery is needed. Wide excision of the primary tumour bed following local excision of a primary melanoma, appendageal carcinoma, malignant connective tissue or merkel cell carcinoma of the skin may be claimed using item 31371, 31372, 31373, 31374, 31375 or 31376, depending on the location of the malignancy and the size of the excision diameter.

For Items 31356 to 31370, a malignant skin lesion is defined as a basal cell carcinoma; a squamous cell carcinoma (including keratoacanthoma); a cutaneous deposit of lymphoma; or a cutaneous metastasis from an internal malignancy.

TN.8.126 Flap Repair - (Item 45202)

Practitioners must only perform a muscle or skin flap repair where clinical need can be clearly evidenced (i.e. where a patient hassevere pre-existing scarring, severe skin atrophy, sclerodermoid changes or where the defect is contiguous witha free margin).

Clinical evidence may be supported by patient notes, photographs of the affected area and pathology reports.

TN.8.127 Interpretation of femoroacetabular impingement (FAI) restriction (items 48424, 49303,49366)

Patients presenting with hip dysplasia, Perthes Disease and Slipped Upper Femoral Epiphysis (SUFE) are eligible for treatment under items 49366, 49303 and 48424.

TN.8.132 Transcatheter occlusion of left atrial appendage for stroke prevention (item 38276)

Explanatory Note

A contraindication to lifelong anticoagulation is defined as:

i) a previous major bleeding complication experienced whilst undergoing treatment with oral anticoagulation therapy,

ii) a blood dyscrasia, or

iii) a vascular abnormality predisposing to potentially life threatening haemorrhage

The procedure is performed as a hospital service.

TN.8.133 Endoscopic upper gastrointestinal strictures (item 30475)

Endoscopic upper GI stricture services 41819 and 41820 have been consolidated under item 30475. This consolidated item will allow any endoscopic technique to be performed for oesophageal through to gastroduodenal procedures and will include imaging intensification if done. The fee is the same as item 41819 which higher than item 30475 but lower than 41820.

TN.8.134 Application of items 32084 and 32087

If a service to which item 32084 or 32087 applies is provided by a practitioner to a patient on more than one occasion on a day, the second service is taken to be a separate service for the purposes of the item if the second service is provided under a second episode of anaesthesia or other sedation.

TN.8.135 Transcatheter Aortic Valve Implantation (Item 38495)

Item 38495 applies only to a service for Transcatheter Aortic Valve Implantation (TAVI) for the treatment of symptomatic severe aortic stenosis, that is to be provided in a TAVI Hospital by a TAVI Practitioner on a TAVI patient.

TAVI Hospital

For item 38495 a TAVI Hospital means a hospital, as defined by subsection 121-5(5) of the Private Health Insurance Act 2007, that is clinically accepted as being a suitable hospital in which the service described in Item 38495 may be performed.

The Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners developed by Cardiac Accreditation Services Limited provides guidance on what are considered by the sector as minimum requirements that must be met in order to be a clinically acceptable facility that is suitable for TAVI procedures to be performed at.

Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners can be accessed via www.tavi.org.au.

TAVI Practitioner

For item 38495 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under item 38495.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners*, issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, *www.tavi.org.au.*

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

TAVI Patient

A TAVI Patient means a patient who, as a result of a TAVI Case Conference, has been assessed as having an unacceptably high risk for surgical aortic valve replacement and is recommended as being suitable to receive the service described in item 38495.

A TAVI Case Conference is a process by which:

(a) there is a team of 3 or more participants, where:

(i) the first participant is a cardiothoracic surgeon; and

(ii) the second participant is an interventional cardiologist; and

(iii) the third participant is a specialist or consultant physician who does not perform a service described in Item 38495 for the patient being assessed; and

(iv) either the first or the second participant is also a TAVI Practitioner; and

(b) the team assesses a patient's risk and technical suitability to receive the service described in Item 38495, taking into account matters such as:

(i) the patient's risk and technical suitability for a surgical aortic valve replacement; and

(ii) the patient's cognitive function and frailty; and

(c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in Item 38495; and

(d) the particulars of the assessment and recommendation are recorded in writing.

While benefits are payable for an eligible TAVI Case Conference under Items 6080 and 6081, a claim for these services does not have to be made in order for a benefit to be paid under Item 38495. Item 38495 is only payable once per patient in a five year period.

TN.8.136 Corneal Collagen Cross Linking (Item 42652)

Evidence of progression in patients over the age of twenty five is determined by the patient history including an objective change in tomography or refraction over time. Evidence of progression in patients aged twenty five years or younger is determined by patient history including an objective change in tomography or refraction over time and/or posterior elevation data and objective documented progression at a subclinical level.

TN.8.137 Thyroidectomy and hemithyroidectomy procedures (items 30296, 30306, and 30310)

Total thyroidectomy or total hemithyroidectomy are the most appropriate procedures in the majority of circumstances when a thyroidectomy is required. The preferred procedure for thyrotoxicosis is total thyroidectomy (item 30296). Item 30310 is to be used only in uncommon circumstances where a subtotal or partial thyroidectomy is indicated and includes a subtotal lobectomy, nodulectomy, or isthmusectomy or equivalent partial thyroidectomy.

TN.8.138 Re-exploratory thyroid surgery (item 30297)

Item 30297 is for re-exploratory thyroid surgery where prior thyroid surgery and associated scar tissue increases the complexity of surgery. For completion hemithyroidectomy on the contralateral side to a previous hemithyroidectomy for thyroid cancer, item 30306 is the appropriate item.

TN.8.139 Personal performance of a Synacthen Stimulation Test (item 30097)

A 0900h serum cortisol (0830-0930) less than 100 nmol/L indicates adrenal deficiency and a Synacthen Test is not required.

A 0900h serum cortisol (0830-0930) greater than 400 nmol/L indicates adrenal sufficiency and a Synacthen Test is not required. An exception to this is when testing women on oral contraception where cortisol levels may be higher due to increases in cortisol-binding globulin and this threshold may not exclude women with adrenal insufficiency.

TN.8.140 Excision of graft material - Items 35581 and 35582

For items 35581 and 35582 the size of the excised graft material must be histologically tested and confirmed.

TN.8.141 Application of items 51011 to 51171 (Sub-group 17)

Spinal surgery items 51011 to 51171 cannot be performed in conjunction with any other item (outside of subgroup 17) in Group T8 of the MBS (surgical operation items 30001 to 50952), when that surgical item is related to spinal surgery. Items 50600 to 50644 - spine surgery for scoliosis and kyphosis in paediatric patients - are excepted from this rule when claimed in conjunction with items 51113 and 51114.

Meaning of Motion Segment

Motion segment is defined as including all anatomical structures (including traversing and exiting nerve roots) between and including the top of the pedicle above to the bottom of the pedicle below.

Combined Anterior and Posterior Surgery

Combined anterior/ posterior surgery items 51061, 51062, 51063, 51064, 51065 and 51066 cannot be claimed with any item between 51020 and 51045 (i.e. items for spinal instrumentation, posterior bone graft and/or anterior column fusion).

Interpretation of Spinal Fusion

Lumbar spinal fusion may not be claimed for chronic low back pain for which a diagnosis has not been made.

TN.8.142 Spinal Decompression - Items 51011 to 51015

Items 51011 to 51015 are for services which include discectomy, decompression of central spinal canal by laminectomy or partial corpectomy (vertebral spurs and osteophytes; less than 50% of the vertebral body), and decompression of the subfacetal recess, the exit foramen and far lateral (intertransverse) space.

For decompression procedures, only one item is selected from 51011 to 51015.

For posterolateral spinal fusion without instrumentation, if a decompression procedure is combined with the fusion, two items numbers can be selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers can be selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items can be selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers can be selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

If more than 50% of a vertebral body is resected (piecemeal vertebrectomy) an item from 51051 to 51059 can be selected in addition to an item from 51011 to 51015.

Items 51011 to 51015 can be used when the purpose of the laminectomy is exposure or posterior spinal release.

TN.8.143 Spinal Instrumentation (cervical, thoracic and lumbar) - Items 51020 to 51026

Items 51020 to 51026 are intended for spinal instrumentation at any level. The appropriate item is determined by the number of motion segments instrumented, barring item 51020 which applies to one vertebra.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

TN.8.144 Posterior and/or Posterolateral (intertransverse or facet joint) bone graft (cervical, thoracic and lumbar) - Items 51031 to 51036

Items 51031 to 51036 are for services which include local morcellized, artificial or harvested bone graft with or without bone morphogenic protein (BMP).

For posterolateral spinal fusion without instrumentation, if a decompression is combined with the fusion, two items numbers are selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumental spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

TN.8.145 Anterior column fusion, with or without implant, or limited vertebrectomy (less than 50%) and anterior fusion (cervical, thoracic and lumbar) - Items 51041 to 51045

Items 51041 to 51045 are for services which include placement of local morcellized, artificial, harvested bone graft, bone morphogenic protein (BMP) and prosthetic devices into the invertebral space. Artificial bone grafting materials must be used in accordance with the manufacturer's instructions.

Items 51041 to 51045 are to be selected irrespective of surgical approach (anterior, direct lateral or posterior via open or minimally invasive techniques).

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

For and instrumented anterior cervical decompression and fusion, (with or without cage) three items are selected: one from 51011 to 51015, one from 51020 to 51026, and one from 51041 to 51045.

Items 51041 to 51045 cannot be claimed with any item between 51051 and 51059 if performed at the same motion segment.

If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item from outside the spinal surgery schedule.

TN.8.146 Spinal Osteotomy and/or vertebrectomy - Items 51051 to 51059

Items 51051 to 51059 are intended for spinal osteotomy and/or vertebrectomy at any level.

For the purpose of items 51054, 51055 and 51056, the definition of piecemeal or subtotal excision is the removal of at least 50% of the vertebral body.

Items 51051 to 51059 cannot be claimed with any item between 51041 and 51045 if performed at the same motion segment.

TN.8.147 Anterior and Posterior (combined) Spinal fusion under one anaesthetic via separate incisions - Items 51061 to 51066

Only one of these items should be billed for any appropriate combined anterior and posterior surgeries which are completed under one anaesthetic. The appropriate item is determined by the number of motion segments to which grafting and fusion occur.

These items cannot be claimed with any item between 51020 to 51026, 51031 to 51036 and 51041 to 51045.

If a laminectomy is included, an item from 51011 to 51015 can also be used appropriate to the level of decompression.

If spinal osteotomy or vertebrectomy (>50%) is performed as part of the combined anterior/posterior approach, it is appropriate to claim one item between 51051 to 51056 in addition to an item between 51061 to 51066.

TN.8.148 Odontoid Screw fixation – Item 51103

This item is not for use when another item is claimed for the management of the odontoid fracture.

TN.8.149 Application of items 51160 and 51166

If the spine surgeon performs their own exposure to the thoracic or lumbar spine then 51160 or 51165 can be added to the claim for the overall surgery. If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item but not in combination with 51160 or 51165. If an exposure surgeon claims a number from any section of the MBS schedule, the spinal surgeon cannot claim 51160 or 51165.

TN.8.150 Correction of Developmental Breast Abnormality - (Items 45060 to 45062)

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

TN.8.151 Mohs surgery service caseload

Services under items 31000, 31001 and 31002 should make up at least 90% of a Mohs surgeon's caseload of items 31000-31005 annually.

TN.8.152 Colonoscopy Items (items 32222-32229)

Colonoscopy items (items 32222-32229)

It is expected that clinicians using the MBS items for colonoscopy also refer to national guidelines such as the National Health and Medical Research Council (NHMRC) Clinical Practice Guidelines for Surveillance Colonoscopy (NHMRC guidelines). For more information on clinical practice guidelines for surveillance colonoscopy see the colorectal cancer pages on the Cancer Council Australia website.

Surveillance colonoscopy should be planned based on high-quality endoscopy in a well-prepared colon using most recent and previous procedure information when histology is known. Clinicians should use their best clinical judgement to determine the interval between testing and the item that best suits the condition of the patient.

The NHMRC guidelines do not support the use of colonoscopy for patients at average or slightly above average risk of colorectal cancer who do not have symptoms or a positive faecal occult blood test (FOBT).

Items 32222-32228 specify that there is endoscopic examination to the caecum. The 'to the caecum' requirements for colonoscopy examinations do not apply to patients who have no caecum following right hemi colectomy. For these patients the examination should be to the anastomosis. Item 32084 should be billed if preparation is inadequate to allow visualisation to the caecum.

General practitioners should ensure colonoscopy referral practices align with applicable national guidelines, including the Royal Australian College of General Practitioners' guidelines for preventive activities in general practice (the red book). In addition, general practitioners are urged to recommend biennial FOBT screening to age-appropriate patients.

Colonoscopy where a polyp/polyps are removed

Items 32222-32226 and 32228 provide for diagnostic colonoscopy when claimed alone. Where a polyp or polyps are removed during the colonoscopy, item 32229 should also be claimed in association with the appropriate colonoscopy item.

Definition of previous history (items 32222-32225)

For items 32223-32225 the most appropriate item to be billed is determined by the previous history of the patient.

The previous history for the purpose of these items is defined by number, size and type of adenomas removed during any previous colonoscopy.

Although with a patient with a previous history of 1-2 low risk adenomas (<10mm with no high-risk histological features) is eligible for a colonoscopy every five years under item 32223, clinical guidlines indicate that colonoscopy every 10 years is sufficient.

Definition of moderate risk of colorectal cancer due to family history (item 32223)
For item 32223 a patient is considered at moderate risk of colorectal cancer if there is moderate risk family history of colorectal cancer – defined as:

- 1 first degree relative less than 55 years of age at diagnosis; OR
- 2 first degree relatives with a history of colorectal cancer; OR
- 1 first degree relative and 2 second degree relatives with a history of colorectal cancer.

The national clinical practice guidelines support the use of FOBT as a first line test for patients with a low risk family history of colorectal cancer.

Exception item (item 32228)
Timing of colonoscopy following polypectomy should conform to the recommended surveillance intervals set out in clinical guidelines, taking into account individualised risk assessment. In the absence of reliable clinical history, clinicians should use their best clinical judgement to determine the interval between testing and the item that best suits the condition of the patient. Where the clinician is unable to access sufficient patient information to enable a colonoscopy to be performed under items 32222-32226, but in their opinion there is a clinical need for a colonoscopy, then item 32228 should be used. This item is available once per patient per lifetime.

Time intervals
Items 32223, 32224, 32225 and 32226 have time intervals for repeat colonoscopy which are consistent with guidelines. These services are payable under Medicare only when provided in accordance with the approved intervals.

Patients may fit several categories and the most appropriate fit is a matter for clinician judgement with the highest risk indicating what subsequent colonoscopy intervals are appropriate. The examples provided below show that the result of the histopathology will not lengthen the surveillance intervals (in the case of patient with familial adenomatous polyposis (FAP) or Lynch syndrome) and may actually shorten the surveillance intervals.

Example 1
A patient at high risk of colorectal cancer with FAP or Lynch syndrome has a number of polyps removed at a surveillance colonoscopy. Item 32226 and 32229 are the appropriate items to bill. If the histology result returns 1-2 adenomas for patients at low to moderate risk then the next surveillance colonoscopy is recommended in 5 years. However, the patient's familial condition means that a shorter interval (12 months) is recommended and payable.

Example 2
A patient at moderate risk of colorectal cancer because of family history has a number of polyps removed at a surveillance colonoscopy. Item 32223 and 32229 are the appropriate items to bill based on the patient's family history. If the histology testing returns showing an adenoma with high-risk histological features then the next surveillance colonoscopy is recommended in 3 years instead of 5 years.

How to use the items with new patients who have undergone previous colonoscopy

Patients whose care continues within one practice should have the relevant history readily available to guide decision making. For new patients, practitioners should make reasonable efforts to establish a patient's previous colonoscopy history. This includes seeking information from My Health Record, the records department of the hospital where the previous procedure occurred, the GP or the patient. The patients' MBS claims history for colonoscopy services will also assist with this.

For audit purposes it is important to record the most appropriate item. In accordance with good practice, clinicians are required to maintain records that include pathology results which must be made available to the patient or other practitioners as required.

The Australian Commission on Safety and Quality in Health Care's 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
The Department of Human Services (DHS) will be able to confirm whether a colonoscopy service has been claimed by an individual patient and the date of service. It will also be able to confirm any restriction on the frequency of the item claimed which would prevent a rebate from being paid if the service was provided again within the restricted period. Patients can seek clarification from the DHS by calling 132 011.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Further information about these services can be found on the Department of Human Services website.

Practitioners providing colonoscopy services can call Medicare on **132 150** to check the patient's claiming history. The patient's Medicare card number will be required together with the range of item numbers to be checked. For example, the new item numbers for colonoscopy services are in the range 32222-32229. The operator will interrogate the patient's claiming history and provide advice on any claims paid for a colonoscopy service within the range of items specified and the date of the service.

Providers can also check a patient's eligibility via 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 DHS enquiry lines for providers and for patients is available 24 hours a day, seven days a week. Further information about these services can be found on the Department of Human Services website.

TN.8.153 Urology Oncology: Intestinal Conduit - (Items 36600 and 36603)
Patients undergoing these procedures should ideally be treated at a facility adequately resourced for stoma therapy support, where High Dependency Units or Intensive Care Units, experienced nursing staff, and stomal therapy is available.

TN.8.154 Urology Oncology: Nephrectomy and Nephroureterectomy - (Items 36516, 36519, 36522, 36528, 36529, 36531, 36532, 36533 and 36576)
Best practice in treating kidney cancer patients with an estimated glomerular filtration rate (eGFR) $<60ml/min/1.73m^2$ 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.9.1 Assistance at Operations - (Items 51300 to 51318)
Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to a surgeon no additional benefits are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

NOTE: The Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more medical practitioners.

Assistance at Multiple Operations

Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Multiple Operation Rule - Surgeon	Multiple Operation Rule - Assistant
Item A - $300@100%	Item A (Assist.) - $300@100%
Item B - $250@50%	Item B (No Assist.)
Item C - $200@25%	Item C (Assist.) - $200@50%
Item D - $150@25%	Item D (Assist.) - $150@25%

The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

Surgeons Operating Independently

Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

TN.9.2 Benefits Payable under Item 51300
Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

TN.9.3 Benefits Payable Under Item 51303

Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

TN.9.4 Benefits Payable Under Item 51309

Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a birth involving Caesarean section.

Where assistance is provided at a Caesarean section birth and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item 51306.

TN.9.5 Assistance at Cataract and Intraocular Lens Surgery - (Item 51318)

The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

TN.10.1 Relative Value Guide For Anaesthetics - (Group T10)

Overview of the RVG

The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

Details of the billing requirements for the RVG are available from the Department of Human Services website.

The RVG is based on an anaesthesia unit system reflecting the complexity of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the MBS fee for anaesthesia in connection with a procedure is comprised of up to three components:

1. The basic units allocated to each anaesthetic procedure, reflecting the complexity of the procedure (an item in the range 20100-21997);

2. The time unit allocation reflecting the total time of the anaesthesia (an item in the range 23010-24136); and

3. Where appropriate, modifying units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020).

Assistance at anaesthesia

To establish the fee for the assistant service items 25200 and 25205, both services have been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers as appropriate to determine the MBS fee.

Whole body perfusion

Where whole body perfusion is performed, the MBS fee is determined by adding together the following:

1. The base units allocated to the service (item 22060);

2. The time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136); and

3. Where appropriate, modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 – 25020).

TN.10.2 Eligible Services

Generally, a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. An "eligible" service is defined as a clinically relevant professional service which is listed in the Schedule and which has been identified as attracting an anaesthetic fee**.**

TN.10.3 RVG Unit Values

Basic Units

The RVG basic unit allocation represents the complexity of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- *for anaesthesia*, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;

- *for assistance at anaesthesia*, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and

- *for perfusion*, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).

Modifying Units (25000 - 25050)

Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000). This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency.

Some examples of clinical situations to which ASA 3 would apply are:

- a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;

- a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;
- a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or
- a patient who has renal failure requiring regular dialysis.

ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item 25005). This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA physical status indicator 4 would be characterised by the following clinical examples:

- a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;
- a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or
- a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:
- severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or
- severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.

ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010). This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

The following are some examples that would equate to ASA physical status indicator 5

- a burst abdominal aneurysm with profound shock;
- major cerebral trauma with increasing intracranial pressure; or
- massive pulmonary embolus.

NOTE: It should be noted that the Medicare Benefits Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2. Some examples of ASA 2 would include:

- A patient with controlled hypertension which has no affect on the patient's normal lifestyle;
- A patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or
- A patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle.
- Where the patient is aged under 4 years old or at least 75 years (item 25013 or 25014).
- For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).

- For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).

- For a perfusion service in association with *after hours emergency surgery (item 25050).

*** NOTE:** It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.

It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

Definition of Emergency

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as existing where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies.

TN.10.4 Deriving the Schedule Fee under the RVG

The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule is derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x $20.10)
20840	Anaesthesia for resection of perforated bowel	6	$120.60
23200	Time - 4 hours 40 minutes	24	$482.40
25000	Modifier - Physical sttaus	1	$20.10
22012	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 provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.8).

It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is

provided under Subgroup 26 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.9)

Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph TN.7.1. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

When a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by the same medical practitioner, then such a block will attract benefit under the appropriate item in Group T7.

It should be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.

The administration of epidural anaesthesia during labour is covered by items 18216 or 18219 (18226 and 18227 for afer hours) in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

For the purposes of items 18216 and 18226, one attendance means that the medical practitioner cannot claim either of these items if the additional attendance is to optimise the initial treatment. Optimise means extension or improvement in analgesic quality of an existing block, without the insertion of a new block as a separate procedure.

TN.10.8 Additional Services Performed in Connection with Anaesthesia - Subgroup 19

Included in the RVG format are a number of additional or complementary services which may be provided in connection with anaesthesia such as blood pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).

These items (with the exception of peri-operative nerve blocks (22031-22042)) and perfusion services (22055-22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.

Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

Items 22012 and 22014

Benefits are payable under items 22012 and 22014 only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of practitioners involved in monitoring the pressures.

Items 22012, 22014 and 22025

A patient who is categorised as having a high risk of complications is one where clinical indications allow for the following items to be claimed (in conjunction with items 22012, 22014 and 22025) with item 25000, item 25005 or item 25010 modifiers, and/or item 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.10.26 Anaesthesia for 2 Dimensional Real Time Transoesophageal Echocardiography - (Item 21936)

Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

TN.10.27 Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and 7)

Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:

- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:

- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;
- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the jejunum, ileum, or colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

TN.10.28 Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865)

Benefits are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Benefits do not apply for microsurgical rotation flaps or for re-implementation of digits or either the hand or the foot.

TN.10.29 Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911)

Benefits are not payable under item 20911 for diagnostic ureteroscopy.

TN.10.30 Credentialing for peri-operative cardiac ultrasound services (22051)

Item 22051 should be performed by a provider who is appropriately credentialed to provide the particular service, by a recognised body for the credentialing of peri-operative cardiac ultrasound services. Credentialing must be based on criteria consistent with those recommended by the Australian and New Zealand College of Anaesthetists in the current version of their Professional Document PS46 "Guidelines on Training and Practice of Perioperative Cardiac Ultrasound in Adults.

TN.11.1 Botulinum Toxin - (Items 18350 to 18379)

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently three botulinum toxin agents with TGA registration (Botox®, Dysport® and Xeomin®). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is recognised as an eligible medical practitioner for the relevant indication under the arrangements under Section 100 of the *National Health Act 1953* (the Act) relating to the use and supply of botulinum toxin. The specialist qualifications required to administer botulinum toxin vary across the indications for which the medicine is listed on the PBS, and are detailed within the relevant PBS restrictions available at: www.pbs.gov.au/browse/section100-mf

Item 18354 for the treatment of equinus, equinovarus or equinovalgus is limited to a maximum of 4 injections per patient on any day (2 per limb). Accounts should be annotated with the limb which has been treated. Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used, in addition to botulinum toxin injection(s), to treat the obturator nerve in patients with a dynamic foot deformity.

Treatment under item 18375 or 18379 can only continue if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline from the start of week 6 through to the end of week 12 after the first treatment. The term 'continue' means the patient can be retreated under item 18375 or 18379 at some point after the 12 week period (for example; 6 to 12 months after the first treatment). This requirement is in line with the PBS listing for the supply of the medicine for this indication under Section 100 of the *Act*.

Item 18362 for the treatment of severe primary axillary hyperhidrosis allows for a maximum number of 3 treatments per patient in a 12 month period, with no less than 4 months to elapse between treatments.

Botulinum toxin which is not supplied and administered in accordance with the arrangements under Section 100 of the *Act* is not required to be provided free of charge to patients. Where a charge is made for the botulinum toxin administered, it must be separately listed on the account and not billed to Medicare. Since 1 September 2015, PBS patient co-payments have applied to botulinum toxin supplied and administered in accordance with the arrangements under Section 100 of the Act.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a patient had a pre-existing condition at the time of the service which is located on the DHS website.

TR.8.1 Mechanical thrombectomy - (Item 35414)

For the purposes of this item, ***eligible stroke centre*** means a facility that:

(a) has a designated stroke unit;

(b) is equipped and has staff available or on call so that it is capable of providing the following to a patient on a 24-hour basis:

(i) the services of a specialist or consultant physician who has the training required under paragraph (b) of item 35414;

(ii) diagnostic imaging services using advanced imaging techniques, which must include computed tomography, computed tomography angiography, digital subtraction angiography, magnetic resonance imaging, and magnetic resonance angiography; and

(iii) care from a team of health practitioners which includes a stroke physician, a neurologist, a neurosurgeon, a radiologist, an anaesthetist, an intensive care unit specialist, a medical imaging technologist, and a nurse;

(c) has dedicated endovascular angiography facilities; and

(d) has written procedures for assessing and treating patients who have, or may have, experienced a stroke.

Note: A health practitioner may fulfil the role of more than one of the types of health practitioner specified in paragraph (b)(iii). For example, a neurologist may also be a stroke physician.

Conjoint Committee for Recognition of Training in Interventional Neuroradiology (CCINR)

CCINR comprises representatives from the Australian and New Zealand Society of Neuroradiology (ANZSNR), the Neurosurgical Society of Australasia (NSA) and the Australian and New Zealand Association of Neurologists (ANZAN). For the purposes of this item, specialists or consultant physicians performing this procedure must have training recognised by CCINR, and the Department of Human Services notified of that recognition.

THERAPEUTIC PROCEDURES ITEMS

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	**1. HYPERBARIC OXYGEN THERAPY**
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 1. Hyperbaric Oxygen Therapy
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:** $262.75 **Benefit:** 75% = $197.10 85% = $223.35
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:** $266.95 **Benefit:** 75% = $200.25 85% = $226.95
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:** $119.30 **Benefit:** 75% = $89.50 85% = $101.45
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:** $168.55 **Benefit:** 75% = $126.45 85% = $143.30

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	**2. DIALYSIS**
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 2. Dialysis
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:** $140.95 **Benefit:** 75% = $105.75 85% = $119.85
13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	2. DIALYSIS
	time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day (See para TN.1.2 of explanatory notes to this Category) **Fee:** $73.45 **Benefit:** 75% = $55.10 85% = $62.45
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:** $152.55 **Benefit:** 85% = $129.70
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:** $610.45 **Benefit:** 100% = $610.45
13106	DECLOTTING OF AN ARTERIOVENOUS SHUNT **Fee:** $125.15 **Benefit:** 75% = $93.90 85% = $106.40
13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.) **Fee:** $234.85 **Benefit:** 75% = $176.15 85% = $199.65
13110	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS , removal of (including catheter cuffs) (Anaes.) **Fee:** $235.65 **Benefit:** 75% = $176.75 85% = $200.35

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	3. ASSISTED REPRODUCTIVE SERVICES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 3. Assisted Reproductive Services
13200	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - INITIAL cycle in a single

	calendar year (See para TN.1.4 of explanatory notes to this Category) **Fee:** $3,207.90 **Benefit:** 75% = $2405.95 85% = $3123.20 **Extended Medicare Safety Net Cap:** $1,714.20
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, 13206, 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:** $3,000.65 **Benefit:** 75% = $2250.50 85% = $2915.95 **Extended Medicare Safety Net Cap:** $2,488.35
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, 13206, 13218, applies being services rendered during 1 treatment cycle (See para TN.1.4 of explanatory notes to this Category) **Fee:** $480.10 **Benefit:** 75% = $360.10 85% = $408.10 **Extended Medicare Safety Net Cap:** $66.45
13203	OVULATION MONITORING SERVICES, for artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which Item 13200, 13201, 13202, 13206, 13212, 13215, 13218, applies (See para TN.1.4 of explanatory notes to this Category) **Fee:** $501.95 **Benefit:** 75% = $376.50 85% = $426.70 **Extended Medicare Safety Net Cap:** $110.65
13206	ASSISTED REPRODUCTIVE TECHNOLOGIES TREATMENT CYCLE using either the natural cycle or oral medication only to induce oocyte growth and development, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies (See para TN.1.4 of explanatory notes to this Category) **Fee:** $480.10 **Benefit:** 75% = $360.10 85% = $408.10 **Extended Medicare Safety Net Cap:** $66.45
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:** $87.35 **Benefit:** 75% = $65.55 85% = $74.25 **Extended Medicare Safety Net Cap:** $11.15
13210	Professional attendance on a patient by a specialist practising in his or her specialty if:

	(a) the attendance is by video conference; and (b) item 13209 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies (See para TN.1.21 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 13209. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** $5.45
13212	Oocyte retrieval for the purpose of assisted reproductive technologies-only if rendered in connection with a service to which item 13200, 13201 or 13206 applies (Anaes.) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $365.50 **Benefit:** 75% = $274.15 85% = $310.70 **Extended Medicare Safety Net Cap:** $72.00
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, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $114.60 **Benefit:** 75% = $85.95 85% = $97.45 **Extended Medicare Safety Net Cap:** $49.85
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, 13206, 13212 applies (Anaes.) (See para TN.1.4, TN.1.5 of explanatory notes to this Category) **Fee:** $818.35 **Benefit:** 75% = $613.80 85% = $733.65 **Extended Medicare Safety Net Cap:** $718.90
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:** $52.35 **Benefit:** 75% = $39.30 85% = $44.50 **Extended Medicare Safety Net Cap:** $22.20

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	3. ASSISTED REPRODUCTIVE SERVICES
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:** $431.00 **Benefit:** 75% = $323.25 85% = $366.35 **Extended Medicare Safety Net Cap:** $110.65
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:** $427.95 **Benefit:** 75% = $321.00 85% = $363.80 **Extended Medicare Safety Net Cap:** $278.20
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:** $210.60 **Benefit:** 75% = $157.95 85% = $179.05
13292	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.) **Fee:** $421.50 **Benefit:** 75% = $316.15 85% = $358.30

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	4. PAEDIATRIC & NEONATAL
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 4. Paediatric & Neonatal
13300	UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate **Fee:** $58.70 **Benefit:** 75% = $44.05 85% = $49.90
13303	UMBILICAL ARTERY CATHETERISATION with or without infusion **Fee:** $87.05 **Benefit:** 75% = $65.30 85% = $74.00
13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor **Fee:** $344.55 **Benefit:** 75% = $258.45 85% = $292.90
13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected **Fee:** $293.75 **Benefit:** 75% = $220.35 85% = $249.70
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	4. PAEDIATRIC & NEONATAL
	Fee: $29.35 **Benefit:** 75% = $22.05 85% = $24.95
13318	CENTRAL VEIN CATHETERISATION - by open exposure in a person under 12 years of age (Anaes.) (See para TN.1.6 of explanatory notes to this Category) **Fee:** $234.55 **Benefit:** 75% = $175.95 85% = $199.40
13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes.) **Fee:** $234.55 **Benefit:** 75% = $175.95 85% = $199.40

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	5. CARDIOVASCULAR
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 5. Cardiovascular
13400	RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.) **Fee:** $99.85 **Benefit:** 75% = $74.90 85% = $84.90

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	6. GASTROENTEROLOGY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 6. Gastroenterology
13506	GASTRO-OESOPHAGEAL balloon intubation, for control of bleeding from gastric oesophageal varices **Fee:** $190.25 **Benefit:** 75% = $142.70 85% = $161.75

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	8. HAEMATOLOGY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 8. Haematology
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.) **Fee:** $343.70 **Benefit:** 75% = $257.80 85% = $292.15
13703	Transfusion of blood, including collection from donor, when used for intra-operative normovolaemic haemodilution **Fee:** $123.20 **Benefit:** 75% = $92.40 85% = $104.75
13706	TRANSFUSION OF BLOOD or bone marrow already collected (See para TN.1.7 of explanatory notes to this Category) **Fee:** $85.95 **Benefit:** 75% = $64.50 85% = $73.10
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:** $140.95 **Benefit:** 75% = $105.75 85% = $119.85
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:** $140.95 **Benefit:** 75% = $105.75 85% = $119.85
13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda **Fee:** $75.20 **Benefit:** 75% = $56.40 85% = $63.95
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:** $786.40 **Benefit:** 75% = $589.80 85% = $701.70

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support
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:** $117.20 **Benefit:** 75% = $87.90 85% = $99.65
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:** $117.25 **Benefit:** 75% = $87.95 85% = $99.70
13830	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day **Fee:** $77.70 **Benefit:** 75% = $58.30 85% = $66.05
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:** $909.30 **Benefit:** 75% = $682.00 85% = $824.60
13834	Veno–arterial cardiopulmonary extracorporeal life support, management of—the first day (See para TN.1.10 of explanatory notes to this Category) **Fee:** $509.05 **Benefit:** 75% = $381.80 85% = $432.70
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:** $118.45 **Benefit:** 75% = $88.85 85% = $100.70
13837	Veno-venous pulmonary extracorporeal life support, management of—the first day (See para TN.1.10 of explanatory notes to this Category) **Fee:** $509.05 **Benefit:** 75% = $381.80 85% = $432.70
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:** $118.45 **Benefit:** 75% = $88.85 85% = $100.70
13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes **Fee:** $23.75 **Benefit:** 75% = $17.85 85% = $20.20
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:** $609.20 **Benefit:** 75% = $456.90 85% = $524.50
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:** $96.50 **Benefit:** 75% = $72.40 85% = $82.05
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:** $161.00 **Benefit:** 75% = $120.75 85% = $136.85
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:** $509.05 **Benefit:** 75% = $381.80 85% = $432.70
13854	Ventricular assist device, management of, for a patient admitted to an intensive care unit, including

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
	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:** $118.45 **Benefit:** 75% = $88.85 85% = $100.70
13857	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 (See para TN.1.10 of explanatory notes to this Category) **Fee:** $151.00 **Benefit:** 75% = $113.25 85% = $128.35

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)*
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:** $373.40 **Benefit:** 75% = $280.05
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:** $277.00 **Benefit:** 75% = $207.75
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:** $79.30 **Benefit:** 75% = $59.50
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)

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
	Fee: $151.00 **Benefit:** 75% = $113.25
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:** $118.85 **Benefit:** 75% = $89.15
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:** $158.45 **Benefit:** 75% = $118.85
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:** $79.30 **Benefit:** 75% = $59.50
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:** $276.25 **Benefit:** 75% = $207.20 85% = $234.85 **Extended Medicare Safety Net Cap:** $500.00

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	11. CHEMOTHERAPEUTIC PROCEDURES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 11. Chemotherapeutic Procedures
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:** $111.40 **Benefit:** 75% = $83.55 85% = $94.70

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 12. Dermatology
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:** $54.40 **Benefit:** 75% = $40.80 85% = $46.25
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:** $157.25 **Benefit:** 75% = $117.95 85% = $133.70 **Extended Medicare Safety Net Cap:** $125.80
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:** $165.15 **Benefit:** 75% = $123.90 85% = $140.40
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:** $264.50 **Benefit:** 75% = $198.40 85% = $224.85
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:** $335.90 **Benefit:** 75% = $251.95 85% = $285.55
14124	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles),

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	12. DERMATOLOGY
	including any associated consultation, if: (a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 to 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $157.25 **Benefit:** 75% = $117.95 85% = $133.70

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	13. OTHER THERAPEUTIC PROCEDURES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 13. Other Therapeutic Procedures
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:** $244.25 **Benefit:** 75% = $183.20 85% = $207.65 **Extended Medicare Safety Net Cap:** $36.65
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:** $123.65 **Benefit:** 75% = $92.75 85% = $105.15 **Extended Medicare Safety Net Cap:** $18.55
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:** $52.75 **Benefit:** 75% = $39.60 85% = $44.85
14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula (See para TN.1.4, TN.1.17 of explanatory notes to this Category) **Fee:** $36.70 **Benefit:** 75% = $27.55 85% = $31.20
14209	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent **Fee:** $91.45 **Benefit:** 75% = $68.60 85% = $77.75
14212	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.) **Fee:** $191.05 **Benefit:** 75% = $143.30 85% = $162.40
14218	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain **Fee:** $101.00 **Benefit:** 75% = $75.75 85% = $85.85
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:** $54.15 **Benefit:** 75% = $40.65 85% = $46.05
14224	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.) **Fee:** $72.55 **Benefit:** 75% = $54.45 85% = $61.70
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:** $101.00 **Benefit:** 75% = $75.75 85% = $85.85
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:** $373.20 **Benefit:** 75% = $279.90
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:** $680.55 **Benefit:** 75% = $510.45
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:** $101.00 **Benefit:** 75% = $75.75 85% = $85.85
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: $1,908.35 **Benefit:** 75% = $1431.30 85% = $1823.65
	Extracorporeal photopheresis for the continuing treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if a. in the preceding 6 months: (i) a service to which item 14247 applies has been provided; and (ii) the patient has demonstrated a response to this service; and (iii)the patient requires further treatment; and b. the service is delivered using an integrated, closed extracorporeal photopheresis system; and c. the patient is 18 years old or over; and d. the service is provided in combination with the use of Pharmaceutical Benefits 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)
14249 S	**Fee:** $1,908.35 **Benefit:** 75% = $1431.30 85% = $1823.65

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 14. Management and Procedures Undertaken in an Emergency Department
	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) (See para TN.1.24 of explanatory notes to this Category)
14255	**Fee:** $153.00 **Benefit:** 75% = $114.75 85% = $130.05
	Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) (See para TN.1.24 of explanatory notes to this Category)
14256	**Fee:** $294.25 **Benefit:** 75% = $220.70 85% = $250.15
	Resuscitation of a patient provided for at least 2 hours, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) (See para TN.1.24 of explanatory notes to this Category)
14257	**Fee:** $586.00 **Benefit:** 75% = $439.50 85% = $501.30
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:** $114.80 **Benefit:** 75% = $86.10 85% = $97.60
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:** $220.70 **Benefit:** 75% = $165.55 85% = $187.60
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:** $439.50 **Benefit:** 75% = $329.65 85% = $373.60
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:** $53.85 **Benefit:** 75% = $40.40 85% = $45.80
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:** $121.25 **Benefit:** 75% = $90.95 85% = $103.10
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:** $40.40 **Benefit:** 75% = $30.30 85% = $34.35
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:** $90.95 **Benefit:** 75% = $68.25 85% = $77.35
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:** $135.95 **Benefit:** 75% = $102.00 85% = $115.60
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $153.00 **Benefit:** 75% = $114.75 85% = $130.05
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:** $114.80 **Benefit:** 75% = $86.10 85% = $97.60
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:** $153.00 **Benefit:** 75% = $114.75 85% = $130.05
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:** $114.80 **Benefit:** 75% = $86.10 85% = $97.60
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:** $153.00 **Benefit:** 75% = $114.75 85% = $130.05
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:** $114.80 **Benefit:** 75% = $86.10 85% = $97.60

T2. RADIATION ONCOLOGY — 1. SUPERFICIAL

	Group T2. Radiation Oncology
	Subgroup 1. Superficial
	(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10) RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given - 1 field
15000	**Fee:** $43.90 **Benefit:** 75% = $32.95 85% = $37.35
	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
15003	**Derived Fee:** The fee for item 15000 plus for each field in excess of 1, an amount of $17.60
	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field
15006	**Fee:** $97.30 **Benefit:** 75% = $73.00 85% = $82.75
	Radiotherapy, superficial attendance at which a single dose technique is applied - 2 or more fields up to a maximum of 5 additional fields
15009	**Derived Fee:** The fee for item 15006 plus for each field in excess of 1, an amount of $19.15
	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye
15012	**Fee:** $55.10 **Benefit:** 75% = $41.35 85% = $46.85

T2. RADIATION ONCOLOGY — 2. ORTHOVOLTAGE

	Group T2. Radiation Oncology

T2. RADIATION ONCOLOGY	2. ORTHOVOLTAGE
	Subgroup 2. Orthovoltage
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:** $49.20 **Benefit:** 75% = $36.90 85% = $41.85
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 $19.40
15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field **Fee:** $58.05 **Benefit:** 75% = $43.55 85% = $49.35
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 $23.40
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field **Fee:** $124.00 **Benefit:** 75% = $93.00 85% = $105.40
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 $48.75

T2. RADIATION ONCOLOGY	3. MEGAVOLTAGE
	Group T2. Radiation Oncology
	Subgroup 3. Megavoltage
15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given - 1 field **Fee:** $56.45 **Benefit:** 75% = $42.35 85% = $48.00

T2. RADIATION ONCOLOGY	3. MEGAVOLTAGE
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 $32.90
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:** $61.50 **Benefit:** 75% = $46.15 85% = $52.30
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:** $61.50 **Benefit:** 75% = $46.15 85% = $52.30
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) **Fee:** $61.50 **Benefit:** 75% = $46.15 85% = $52.30
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:** $61.50 **Benefit:** 75% = $46.15 85% = $52.30
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:** $61.50 **Benefit:** 75% = $46.15 85% = $52.30
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 $39.15
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 $39.15
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 $39.15
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 $39.15
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 $39.15
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:** $61.50 **Benefit:** 75% = $46.15 85% = $52.30
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:** $61.50 **Benefit:** 75% = $46.15 85% = $52.30
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:** $61.50 **Benefit:** 75% = $46.15 85% = $52.30
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:** $61.50 **Benefit:** 75% = $46.15 85% = $52.30
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:** $61.50 **Benefit:** 75% = $46.15 85% = $52.30
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 $39.15
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 $39.15
15266	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast)

T2. RADIATION ONCOLOGY	3. MEGAVOLTAGE
	Derived Fee: The fee for item 15251 plus for each field in excess of 1, an amount of $39.15
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 $39.15
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 $39.15
15275	RADIATION ONCOLOGY TREATMENT with IGRT imaging facilities undertaken: (a) to implement an IMRT dosimetry plan prepared in accordance with item 15565; and (b) utilising an intensity modulated treatment delivery mode (delivered by a fixed or dynamic gantry linear accelerator or by a helical non C-arm based linear accelerator), once only at each attendance at which treatment is given. **Fee:** $188.65 **Benefit:** 75% = $141.50 85% = $160.40

T2. RADIATION ONCOLOGY	4. BRACHYTHERAPY
	Group T2. Radiation Oncology
	Subgroup 4. Brachytherapy
15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $368.15 **Benefit:** 75% = $276.15 85% = $312.95
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $368.15 **Benefit:** 75% = $276.15 85% = $312.95
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:** $697.95 **Benefit:** 75% = $523.50 85% = $613.25
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:** $697.95 **Benefit:** 75% = $523.50 85% = $613.25
15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $343.65 **Benefit:** 75% = $257.75 85% = $292.15
15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater

	than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $341.15 **Benefit:** 75% = $255.90 85% = $290.00
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:** $674.65 **Benefit:** 75% = $506.00 85% = $589.95
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:** $674.65 **Benefit:** 75% = $506.00 85% = $589.95
15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $418.75 **Benefit:** 75% = $314.10 85% = $355.95
15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $418.75 **Benefit:** 75% = $314.10 85% = $355.95
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:** $744.55 **Benefit:** 75% = $558.45 85% = $659.85
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:** $744.55 **Benefit:** 75% = $558.45 85% = $659.85
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:** $809.95 **Benefit:** 75% = $607.50 85% = $725.25
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:** $809.95 **Benefit:** 75% = $607.50 85% = $725.25
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:** $769.10 **Benefit:** 75% = $576.85 85% = $684.40
15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical

	exposure and using automatic afterloading techniques (Anaes.) **Fee:** $769.10 **Benefit:** 75% = $576.85 85% = $684.40
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:** $697.95 **Benefit:** 75% = $523.50 85% = $613.25
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:** $697.95 **Benefit:** 75% = $523.50 85% = $613.25
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:** $964.80 **Benefit:** 75% = $723.60 85% = $880.10
15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.) **Fee:** $78.55 **Benefit:** 75% = $58.95 85% = $66.80
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:** $196.25 **Benefit:** 75% = $147.20 85% = $166.85
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:** $523.65 **Benefit:** 75% = $392.75 85% = $445.15
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance **Fee:** $60.25 **Benefit:** 75% = $45.20 85% = $51.25
15351	CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not

T2. RADIATION ONCOLOGY	4. BRACHYTHERAPY
	exceeding 5 cm. diameter to an external surface **Fee:** $120.25 **Benefit:** 75% = $90.20 85% = $102.25
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface **Fee:** $145.90 **Benefit:** 75% = $109.45 85% = $124.05
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:** $41.30 **Benefit:** 75% = $31.00 85% = $35.15

T2. RADIATION ONCOLOGY	5. COMPUTERISED PLANNING
	Group T2. Radiation Oncology
	Subgroup 5. Computerised Planning
	RADIOTHERAPY PLANNING 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)
15500	**Fee:** $250.25 **Benefit:** 75% = $187.70 85% = $212.75
	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)
15503	**Fee:** $321.30 **Benefit:** 75% = $241.00 85% = $273.15
	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)
15506	**Fee:** $479.85 **Benefit:** 75% = $359.90 85% = $407.90
	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)
15509	**Fee:** $216.85 **Benefit:** 75% = $162.65 85% = $184.35
	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)
15512	**Fee:** $279.60 **Benefit:** 75% = $209.70 85% = $237.70
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:** $316.10 **Benefit:** 75% = $237.10 85% = $268.70
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:** $404.80 **Benefit:** 75% = $303.60 85% = $344.10
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:** $79.40 **Benefit:** 75% = $59.55 85% = $67.50
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:** $350.55 **Benefit:** 75% = $262.95 85% = $298.00
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:** $657.25 **Benefit:** 75% = $492.95 85% = $572.55
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:** $81.40 **Benefit:** 75% = $61.05 85% = $69.20
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:** $363.15 **Benefit:** 75% = $272.40 85% = $308.70
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:** $688.60 **Benefit:** 75% = $516.45 85% = $603.90
15536	BRACHYTHERAPY PLANNING, computerised radiation dosimetry (See para TN.2.3 of explanatory notes to this Category) **Fee:** $275.20 **Benefit:** 75% = $206.40 85% = $233.95
15539	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338

	(See para TN.2.3 of explanatory notes to this Category) **Fee:** $646.90 **Benefit:** 75% = $485.20 85% = $562.20
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:** $679.20 **Benefit:** 75% = $509.40 85% = $594.50
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:** $732.75 **Benefit:** 75% = $549.60 85% = $648.05
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:** $732.75 **Benefit:** 75% = $549.60 85% = $648.05
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:** $685.20 **Benefit:** 75% = $513.90 85% = $600.50
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:** $893.60 **Benefit:** 75% = $670.20 85% = $808.90
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:** $1,155.80 **Benefit:** 75% = $866.85 85% = $1071.10
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

T2. RADIATION ONCOLOGY	5. COMPUTERISED PLANNING
	completed on a linear accelerator; and (iii) validating the accuracy of the derived IMRT dosimetry plan; and (c) the final IMRT dosimetry plan is approved by the radiation oncologist prior to delivery. (See para TN.2.3 of explanatory notes to this Category) **Fee:** $3,417.35 **Benefit:** 75% = $2563.05 85% = $3332.65

T2. RADIATION ONCOLOGY	6. STEREOTACTIC RADIOSURGERY
	Group T2. Radiation Oncology
	Subgroup 6. Stereotactic Radiosurgery
15600	STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment **Fee:** $1,755.50 **Benefit:** 75% = $1316.65 85% = $1670.80

T2. RADIATION ONCOLOGY	7. RADIATION ONCOLOGY TREATMENT VERIFICATION
	Group T2. Radiation Oncology
	Subgroup 7. Radiation Oncology Treatment Verification
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 (ie maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category) **Fee:** $47.40 **Benefit:** 75% = $35.55 85% = $40.30
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 (ie maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category) **Fee:** $79.00 **Benefit:** 75% = $59.25 85% = $67.15
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 (ie 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:** $79.00 **Benefit:** 75% = $59.25 85% = $67.15
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

T2. RADIATION ONCOLOGY	7. RADIATION ONCOLOGY TREATMENT VERIFICATION
	reduced to minimise treatment related exposure of healthy or normal tissues; and (c) the decisions made using acquired images are based on action algorithms and are given effect immediately prior to or during treatment delivery by qualified and trained staff considering complex competing factors and using software driven modelling programs; and (d) the radiation treatment field positioning requires accuracy levels of less than 5mm (curative cases) or up to 10mm (palliative cases) to ensure accurate dose delivery to the target; and (e) the image decisions and actions are documented in the patient's record; and (f) the radiation oncologist is responsible for supervising the process, including specifying the type and frequency of imaging, tolerance and action levels to be incorporated in the process, reviewing the trend analysis and any reports and relevant images during the treatment course and specifying action protocols as required; and (g) when treatment adjustments are inadequate to satisfy treatment protocol requirements, replanning is required; and (h) the imaging infrastructure (hardware and software) is linked to the treatment unit and networked to an image database, enabling both on line and off line reviews. (See para TN.2.4 of explanatory notes to this Category) **Fee:** $79.00 **Benefit:** 75% = $59.25 85% = $67.15

T2. RADIATION ONCOLOGY	8. BRACHYTHERAPY PLANNING AND VERIFICATION
	Group T2. Radiation Oncology
	Subgroup 8. Brachytherapy Planning And Verification
15800	BRACHYTHERAPY TREATMENT VERIFICATION - maximum of one only for each attendance. (See para TN.2.4 of explanatory notes to this Category) **Fee:** $99.30 **Benefit:** 75% = $74.50 85% = $84.45
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:** $205.75 **Benefit:** 75% = $154.35 85% = $174.90

T2. RADIATION ONCOLOGY	10. TARGETED INTRAOPERATIVE RADIOTHERAPY
	Group T2. Radiation Oncology
	Subgroup 10. Targeted Intraoperative Radiotherapy
	INTRAOPERATIVE RADIOTHERAPY
Amend 15900	BREAST, MALIGNANT TUMOUR, targeted intraoperative radiation therapy, using an Intrabeam® or Xoft® Axxent® device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who:

T2. RADIATION ONCOLOGY	10. TARGETED INTRAOPERATIVE RADIOTHERAPY
	a) is 45 years of age or more; and b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and c) has an histologic Grade 1 or 2 tumour; and d) has an oestrogen-receptor positive tumour; and e) has a node negative malignancy; and f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and g) has no contra-indications to breast irradiation Applicable only once per breast per lifetime (H) **Fee:** $257.80 **Benefit:** 75% = $193.35
T3. THERAPEUTIC NUCLEAR MEDICINE	
	Group T3. Therapeutic Nuclear Medicine
16003	INTRACAVITY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.) (See para TN.3.1 of explanatory notes to this Category) **Fee:** $670.80 **Benefit:** 75% = $503.10 85% = $586.10
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique **Fee:** $515.45 **Benefit:** 75% = $386.60 85% = $438.15
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique **Fee:** $351.80 **Benefit:** 75% = $263.85 85% = $299.05
16012	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32 **Fee:** $304.35 **Benefit:** 75% = $228.30 85% = $258.70
16015	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either: (i) the disease is poorly controlled by conventional radiotherapy; or (ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain **Fee:** $4,213.30 **Benefit:** 75% = $3160.00 85% = $4128.60
16018	ADMINISTRATION OF ^{153} SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) where hormonal therapy and/or chemotherapy have failed and either the disease is poorly controlled by conventional radiotherapy or conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain. **Fee:** $2,518.75 **Benefit:** 75% = $1889.10 85% = $2434.05

T4. OBSTETRICS	
	Group T4. Obstetrics
16399	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if: (a) the attendance is by video conference; and (b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies (See para TN.4.12 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 16401,16404,16406,16500,16590 or 16591. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** $24.65
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:** $28.10 **Benefit:** 85% = $23.90 **Extended Medicare Safety Net Cap:** $11.35
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:** $88.20 **Benefit:** 75% = $66.15 85% = $75.00 **Extended Medicare Safety Net Cap:** $56.20
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:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $33.75

T4. OBSTETRICS	
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:** $138.15 **Benefit:** 75% = $103.65 85% = $117.45 **Extended Medicare Safety Net Cap:** $110.65
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:** $73.95 **Benefit:** 75% = $55.50 85% = $62.90 **Extended Medicare Safety Net Cap:** $48.10
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:** $55.05 **Benefit:** 85% = $46.80 **Extended Medicare Safety Net Cap:** $35.80
16500	ANTENATAL ATTENDANCE (See para TN.4.3, TN.4.15 of explanatory notes to this Category) **Fee:** $48.60 **Benefit:** 75% = $36.45 85% = $41.35 **Extended Medicare Safety Net Cap:** $33.75
16501	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication

T4. OBSTETRICS	
	exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy (See para TN.4.3, TN.4.4 of explanatory notes to this Category) **Fee:** $144.95 **Benefit:** 75% = $108.75 85% = $123.25 **Extended Medicare Safety Net Cap:** $67.40
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:** $48.60 **Benefit:** 75% = $36.45 85% = $41.35 **Extended Medicare Safety Net Cap:** $22.50
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:** $48.60 **Benefit:** 75% = $36.45 85% = $41.35 **Extended Medicare Safety Net Cap:** $22.50
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 (See para TN.4.3 of explanatory notes to this Category) **Fee:** $48.60 **Benefit:** 75% = $36.45 85% = $41.35 **Extended Medicare Safety Net Cap:** $22.50
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:** $48.60 **Benefit:** 75% = $36.45 85% = $41.35 **Extended Medicare Safety Net Cap:** $22.50
16511	CERVIX, purse string ligation of (Anaes.) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $226.80 **Benefit:** 75% = $170.10 85% = $192.80 **Extended Medicare Safety Net Cap:** $112.30
16512	CERVIX, removal of purse string ligature of (Anaes.) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $65.45 **Benefit:** 75% = $49.10 85% = $55.65 **Extended Medicare Safety Net Cap:** $33.75
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:** $37.80 **Benefit:** 75% = $28.35 85% = $32.15 **Extended Medicare Safety Net Cap:** $16.90
16515	Management of vaginal birth as an independent procedure, if the patient's care has been transferred by

T4. OBSTETRICS	
	another medical practitioner for management of the birth and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the birth (Anaes.) (See para TN.4.5, TN.4.10 of explanatory notes to this Category) **Fee:** $650.55 **Benefit:** 75% = $487.95 85% = $565.85 **Extended Medicare Safety Net Cap:** $179.65
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:** $464.70 **Benefit:** 75% = $348.55 85% = $395.00 **Extended Medicare Safety Net Cap:** $179.65
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:** $715.65 **Benefit:** 75% = $536.75 85% = $630.95 **Extended Medicare Safety Net Cap:** $336.75
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:** $650.55 **Benefit:** 75% = $487.95 85% = $565.85 **Extended Medicare Safety Net Cap:** $336.75
16522	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:

T4. OBSTETRICS	
	(i) scalp pH less than 7.15; or (ii) scalp lactate greater than 4.0; (j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities: (i) prolonged bradycardia (less than 100 bpm for more than 2 minutes); (ii) absent baseline variability (less than 3 bpm); (iii) sinusoidal pattern; (iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability; (v) late decelerations; (k) pregnancy induced hypertension of at least 140/90 mm Hg associated with: (i) at least 2+ proteinuria on urinalysis; or (ii) protein-creatinine ratio greater than 30 mg/mmol; or (iii) platelet count less than 150 x 10^9/L; or (iv) uric acid greater than 0.36 mmol/L; (l) gestational diabetes mellitus requiring at least daily blood glucose monitoring; (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by: (i) the patient requiring hospitalisation; or (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or (iii) the patient having a GP mental health treatment plan; or (iv) the patient having a management plan prepared in accordance with item 291; (n) disclosure or evidence of domestic violence; (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation: (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy; (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction); (iii) previous renal or liver transplant; (iv) renal dialysis; (v) chronic liver disease with documented oesophageal varices;

T4. OBSTETRICS	
	(vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L); (vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy; (viii) maternal height of less than 148 cm; (ix) a body mass index greater than or equal to 40; (x) pre-existing diabetes mellitus on medication prior to pregnancy; (xi) thyrotoxicosis requiring medication; (xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium; (xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation; (xiv) HIV, hepatitis B or hepatitis C carrier status positive; (xv) red cell or platelet iso-immunisation; (xvi) cancer with metastatic disease; (xvii) illicit drug misuse during pregnancy (Anaes.) (See para TN.4.7 of explanatory notes to this Category) **Fee:** $1,680.25 **Benefit:** 75% = $1260.20
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:** $650.55 **Benefit:** 75% = $487.95 85% = $565.85 **Extended Medicare Safety Net Cap:** $179.65
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:** $650.55 **Benefit:** 75% = $487.95 85% = $565.85 **Extended Medicare Safety Net Cap:** $336.75
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:** $396.35 **Benefit:** 75% = $297.30 85% = $336.90 **Extended Medicare Safety Net Cap:** $257.65
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:** $792.70 **Benefit:** 75% = $594.55
16533	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy,

T4. OBSTETRICS	
	requiring admission to hospital—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy (See para TN.4.3, TN.4.14 of explanatory notes to this Category) **Fee:** $108.85 **Benefit:** 75% = $81.65
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:** $108.85 **Benefit:** 75% = $81.65
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:** $224.80 **Benefit:** 75% = $168.60 85% = $191.10 **Extended Medicare Safety Net Cap:** $224.50
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:** $328.75 **Benefit:** 75% = $246.60 85% = $279.45 **Extended Medicare Safety Net Cap:** $224.50
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:** $429.05 **Benefit:** 75% = $321.80 85% = $364.70 **Extended Medicare Safety Net Cap:** $224.50
16571	CERVIX, repair of extensive laceration or lacerations (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $328.75 **Benefit:** 75% = $246.60 85% = $279.45 **Extended Medicare Safety Net Cap:** $224.50
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:** $267.90 **Benefit:** 75% = $200.95 85% = $227.75 **Extended Medicare Safety Net Cap:** $224.50
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:** $384.40 **Benefit:** 75% = $288.30 85% = $326.75 **Extended Medicare Safety Net Cap:** $224.50
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:** $147.10 **Benefit:** 75% = $110.35 85% = $125.05 **Extended Medicare Safety Net Cap:** $112.30
	INTERVENTIONAL TECHNIQUES
16600	AMNIOCENTESIS, diagnostic (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $65.45 **Benefit:** 75% = $49.10 85% = $55.65 **Extended Medicare Safety Net Cap:** $33.75
16603	CHORIONIC VILLUS SAMPLING, by any route (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $125.65 **Benefit:** 75% = $94.25 85% = $106.85 **Extended Medicare Safety Net Cap:** $67.40
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:** $250.85 **Benefit:** 75% = $188.15 85% = $213.25 **Extended Medicare Safety Net Cap:** $134.80
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:** $511.50 **Benefit:** 75% = $383.65 85% = $434.80 **Extended Medicare Safety Net Cap:** $258.25
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:** $402.45 **Benefit:** 75% = $301.85 85% = $342.10
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:** $214.35 **Benefit:** 75% = $160.80 85% = $182.20
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:** $214.35 **Benefit:** 75% = $160.80 85% = $182.20 **Extended Medicare Safety Net Cap:** $106.70
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:** $214.35 **Benefit:** 75% = $160.80 85% = $182.20
16624	FOETAL FLUID FILLED CAVITY, drainage of (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $262.20 **Extended Medicare Safety Net Cap:** $145.95
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:** $628.00 **Benefit:** 75% = $471.00 85% = $543.30 **Extended Medicare Safety Net Cap:** $314.35

	Group T4. Obstetrics
	Subgroup 1. COVID-19 Obstetric Telehealth Services
91850	Antenatal telehealth service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, to a maximum of 10 services per pregnancy, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is provided at, or from, a practice location in a regional, rural or remote area; and (c) the service is not performed in conjunction with another antenatal attendance item in Group T4 for the same patient on the same day by the same practitioner. **Fee:** $28.10 **Benefit:** 85% = $23.90
91851	Postnatal telehealth attendance by an obstetrician or general practitioner (other than a service to which

T4. OBSTETRICS	1. COVID-19 OBSTETRIC TELEHEALTH SERVICES
	any other item applies) if: (a) is between 4 and 8 weeks after the birth; and (b) lasts at least 20 minutes in duration; and (c) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (d) is for a pregnancy in relation to which a service to which item 82140 applies is not provided. Applicable once for a pregnancy **Fee:** $73.95 **Benefit:** 85% = $62.90
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 (iii) a general practitioner; and (b) is between 1 week and 4 weeks after the birth; and (c) lasts at least 20 minutes; and (d) is for a patient who was privately admitted for the birth; and (e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided. Applicable once for a pregnancy **Fee:** $55.05 **Benefit:** 85% = $46.80
91853	Antenatal telehealth attendance. **Fee:** $48.60 **Benefit:** 85% = $41.35

T4. OBSTETRICS	2. COVID-19 OBSTETRIC PHONE SERVICES

	Group T4. Obstetrics
	Subgroup 2. COVID-19 Obstetric Phone Services
91855	Antenatal phone service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, to a maximum of 10 services per pregnancy, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is provided at, or from, a practice location in a regional, rural or remote area; and (c) the service is not performed in conjunction with another antenatal attendance item in Group T4 for the same patient on the same day by the same practitioner. **Fee:** $28.10 **Benefit:** 85% = $23.90
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 (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:** $73.95 **Benefit:** 85% = $62.90
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

T4. OBSTETRICS	2. COVID-19 OBSTETRIC PHONE SERVICES
	(e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided. Applicable once for a pregnancy **Fee:** $55.05 **Benefit:** 85% = $46.80
91858	Antenatal phone attendance. **Fee:** $48.60 **Benefit:** 85% = $41.35

T6. ANAESTHETICS	1. ANAESTHESIA CONSULTATIONS
	Group T6. Anaesthetics
	Subgroup 1. Anaesthesia Consultations
17609	Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if: (a) the attendance is by video conference; and (b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies (See para TN.6.4 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
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:** $45.00 **Benefit:** 75% = $33.75 85% = $38.25 **Extended Medicare Safety Net Cap:** $135.00
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:** $89.55 **Benefit:** 75% = $67.20 85% = $76.15 **Extended Medicare Safety Net Cap:** $268.65
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:** $124.05 **Benefit:** 75% = $93.05 85% = $105.45 **Extended Medicare Safety Net Cap:** $372.15
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:** $157.95 **Benefit:** 75% = $118.50 85% = $134.30 **Extended Medicare Safety Net Cap:** $473.85
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:** $45.00 **Benefit:** 75% = $33.75 85% = $38.25 **Extended Medicare Safety Net Cap:** $135.00
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:** $89.55 **Benefit:** 75% = $67.20 85% = $76.15 **Extended Medicare Safety Net Cap:** $268.65
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:** $124.05 **Benefit:** 75% = $93.05 85% = $105.45 **Extended Medicare Safety Net Cap:** $372.15
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:** $157.95 **Benefit:** 75% = $118.50 85% = $134.30 **Extended Medicare Safety Net Cap:** $473.85
17680	ANAESTHETIST, CONSULTATION, OTHER (Professional attendance by an anaesthetist in the practice of ANAESTHESIA)

T6. ANAESTHETICS	1. ANAESTHESIA CONSULTATIONS
	- a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 - 3000 apply. (See para TN.6.3 of explanatory notes to this Category) **Fee:** $89.55 **Benefit:** 75% = $67.20 85% = $76.15 **Extended Medicare Safety Net Cap:** $268.65
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:** $41.40 **Benefit:** 75% = $31.05 85% = $35.20 **Extended Medicare Safety Net Cap:** $124.20
T7. REGIONAL OR FIELD NERVE BLOCKS	
	Group T7. Regional Or Field Nerve Blocks
18213	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion **Fee:** $91.40 **Benefit:** 75% = $68.55 85% = $77.70
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) **Fee:** $195.85 **Benefit:** 75% = $146.90 85% = $166.50
18219	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by the medical practitioner extends beyond the first hour (Anaes.)

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Derived Fee: The fee for item 18216 plus $19.60 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.
18222	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less (See para TN.7.2, TN.10.7 of explanatory notes to this Category) **Fee:** $38.80 **Benefit:** 75% = $29.10 85% = $33.00
18225	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes (See para TN.7.2, TN.10.7 of explanatory notes to this Category) **Fee:** $51.60 **Benefit:** 75% = $38.70 85% = $43.90
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:** $293.70 **Benefit:** 75% = $220.30 85% = $249.65
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 $29.50 for each additional 15 minutes or part there of beyond the first hour of attendance by the medical practitioner.
18228	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance **Fee:** $64.45 **Benefit:** 75% = $48.35 85% = $54.80
18230	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.) **Fee:** $245.90 **Benefit:** 75% = $184.45 85% = $209.05
18232	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.) (See para TN.7.3 of explanatory notes to this Category) **Fee:** $195.85 **Benefit:** 75% = $146.90 85% = $166.50
18233	EPIDURAL INJECTION of blood for blood patch (Anaes.) **Fee:** $195.85 **Benefit:** 75% = $146.90 85% = $166.50
18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
18236	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category)

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Fee: $64.45 **Benefit:** 75% = $48.35 85% = $54.80
18238	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies (See para TN.7.5 of explanatory notes to this Category) **Fee:** $38.80 **Benefit:** 75% = $29.10 85% = $33.00
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $96.55 **Benefit:** 75% = $72.45 85% = $82.10
18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $38.80 **Benefit:** 75% = $29.10 85% = $33.00
18244	VAGUS NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40
18248	PHRENIC NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $91.40 **Benefit:** 75% = $68.55 85% = $77.70
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $64.45 **Benefit:** 75% = $48.35 85% = $54.80
18252	CERVICAL PLEXUS, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40
18254	BRACHIAL PLEXUS, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $64.45 **Benefit:** 75% = $48.35 85% = $54.80
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $64.45 **Benefit:** 75% = $48.35 85% = $54.80
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $91.40 **Benefit:** 75% = $68.55 85% = $77.70
18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $64.45 **Benefit:** 75% = $48.35 85% = $54.80

T7. REGIONAL OR FIELD NERVE BLOCKS	
18264	PUDENDAL NERVE and or dorsal nerve, injection of anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40
18266	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block (See para TN.7.5 of explanatory notes to this Category) **Fee:** $64.45 **Benefit:** 75% = $48.35 85% = $54.80
18268	OBTURATOR NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $91.40 **Benefit:** 75% = $68.55 85% = $77.70
18270	FEMORAL NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $91.40 **Benefit:** 75% = $68.55 85% = $77.70
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) **Fee:** $64.45 **Benefit:** 75% = $48.35 85% = $54.80
18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $91.40 **Benefit:** 75% = $68.55 85% = $77.70
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
18278	SCIATIC NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $91.40 **Benefit:** 75% = $68.55 85% = $77.70
18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
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:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40
18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $152.25 **Benefit:** 75% = $114.20 85% = $129.45
18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $152.25 **Benefit:** 75% = $114.20 85% = $129.45

T7. REGIONAL OR FIELD NERVE BLOCKS	
18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $152.25 **Benefit:** 75% = $114.20 85% = $129.45
18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.) **Fee:** $257.55 **Benefit:** 75% = $193.20 85% = $218.95
18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.) **Fee:** $181.50 **Benefit:** 75% = $136.15 85% = $154.30
18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $155.25 **Benefit:** 75% = $116.45 85% = $132.00
18297	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $181.50 **Benefit:** 75% = $136.15 85% = $154.30

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
30003	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation **Fee:** $37.45 **Benefit:** 75% = $28.10 85% = $31.85
30006	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation **Fee:** $47.95 **Benefit:** 75% = $36.00 85% = $40.80
30010	LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) **Fee:** $76.25 **Benefit:** 75% = $57.20
30014	EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)

	Fee: $160.25 **Benefit:** 75% = $120.20
30017	BURNS, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.) **Fee:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80
30020	BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.) **Fee:** $654.85 **Benefit:** 75% = $491.15
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 of explanatory notes to this Category) **Fee:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80
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:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80
30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $53.85 **Benefit:** 75% = $40.40 85% = $45.80
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:** $92.80 **Benefit:** 75% = $69.60 85% = $78.90
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:** $85.05 **Benefit:** 75% = $63.80 85% = $72.30
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:** $121.25 **Benefit:** 75% = $90.95 85% = $103.10
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:** $92.80 **Benefit:** 75% = $69.60 85% = $78.90
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:** $191.40 **Benefit:** 75% = $143.55 85% = $162.70
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:** $121.25 **Benefit:** 75% = $90.95 85% = $103.10
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:** $191.40 **Benefit:** 75% = $143.55 85% = $162.70
30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) **Fee:** $261.90 **Benefit:** 75% = $196.45 85% = $222.65
30055	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $76.25 **Benefit:** 75% = $57.20 85% = $64.85
30058	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.) **Fee:** $148.85 **Benefit:** 75% = $111.65 85% = $126.55
30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.) **Fee:** $24.25 **Benefit:** 75% = $18.20 85% = $20.65
30062	Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.) **Fee:** $62.65 **Benefit:** 75% = $47.00 85% = $53.30
30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.) **Fee:** $113.30 **Benefit:** 75% = $85.00 85% = $96.35
30068	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $285.45 **Benefit:** 75% = $214.10 85% = $242.65
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:** $53.85 **Benefit:** 75% = $40.40 85% = $45.80 **Extended Medicare Safety Net Cap:** $43.10
30072	Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy specimen is sent for

	pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $53.85 **Benefit:** 75% = $40.40 85% = $45.80
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:** $154.45 **Benefit:** 75% = $115.85 85% = $131.30
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:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50
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:** $113.30 **Benefit:** 75% = $85.00 85% = $96.35
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:** $60.65 **Benefit:** 75% = $45.50 85% = $51.60
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:** $30.35 **Benefit:** 75% = $22.80 85% = $25.80
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:** $132.55 **Benefit:** 75% = $99.45 85% = $112.70
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:** $176.90 **Benefit:** 75% = $132.70 85% = $150.40
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:** $195.35 **Benefit:** 75% = $146.55 85% = $166.05
30096	DIAGNOSTIC SCALENE NODE BIOPSY, by open procedure, where the specimen excised is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $189.65 **Benefit:** 75% = $142.25 85% = $161.25
30097	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented, if:

	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:** $100.20 **Benefit:** 75% = $75.15 85% = $85.20
30099	SINUS, excision of, involving superficial tissue only (Anaes.) **Fee:** $92.80 **Benefit:** 75% = $69.60 85% = $78.90
30103	SINUS, excision of, involving muscle and deep tissue (Anaes.) **Fee:** $189.65 **Benefit:** 75% = $142.25 85% = $161.25
30104	PRE-AURICULAR SINUS, on a person 10 years of age or over. Excision of, (Anaes.) **Fee:** $130.90 **Benefit:** 75% = $98.20 85% = $111.30
30105	PRE-AURICULAR SINUS, on a person under 10 years of age. Excision of, (Anaes.) **Fee:** $170.10 **Benefit:** 75% = $127.60 85% = $144.60
30107	GANGLION OR SMALL BURSA, excision of, other than a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $226.80 **Benefit:** 75% = $170.10 85% = $192.80
30111	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes.) (Assist.) **Fee:** $383.10 **Benefit:** 75% = $287.35 85% = $325.65
30114	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.) **Fee:** $383.10 **Benefit:** 75% = $287.35
30165	Lipectomy, wedge excision of abdominal apron that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30168, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the abdominal apron interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $469.10 **Benefit:** 75% = $351.85
30168	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and

	(b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 1 excision only (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $469.10 **Benefit:** 75% = $351.85
30171	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 2 excisions only (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $713.35 **Benefit:** 75% = $535.05
30172	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30171, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 3 or more excisions (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $713.35 **Benefit:** 75% = $535.05
30176	Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 45564 or 45565 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $1,016.45 **Benefit:** 75% = $762.35

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 (Pitanguy type or similar), with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $1,016.45 **Benefit:** 75% = $762.35
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 (Pitanguy type or similar), not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if: (a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $1,251.05 **Benefit:** 75% = $938.30
30180	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.) **Fee:** $140.80 **Benefit:** 75% = $105.60 85% = $119.70
30183	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.) **Fee:** $254.20 **Benefit:** 75% = $190.65 85% = $216.10
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:** $264.95 **Benefit:** 75% = $198.75 85% = $225.25
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:** $151.90 **Benefit:** 75% = $113.95

	Angiofibromas, trichoepitheliomas or other severely disfiguring tumours of the face or neck (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), suitable for laser ablation as confirmed by the opinion of a specialist in the specialty of dermatology—removal of, by carbon dioxide laser or erbium laser ablation, including associated resurfacing (10 or more tumours) (Anaes.)
30190	**Fee:** $410.15 **Benefit:** 75% = $307.65 85% = $348.65
	Angiofibromas, trichoepithelioma, epidermal naevi, xanthelasma, pyogenic granuloma, genital angiokeratomas, hereditary haemorrhagic telangiectasia and other severely disfiguring or recurrently bleeding tumours (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), treatment of, with carbon dioxide/erbium or other appropriate laser (or curettage and fine point diathermy for pyogenic granuloma only), if confirmed by the opinion of a specialist in the specialty of dermatology, one or more lesions.
30191	**Fee:** $65.45 **Benefit:** 75% = $49.10 85% = $55.65
	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) (See para TN.8.9 of explanatory notes to this Category)
30192	**Fee:** $40.80 **Benefit:** 75% = $30.60 85% = $34.70
	Malignant neoplasm of skin or mucous membrane that has been: (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.) (See para TN.8.10 of explanatory notes to this Category)
Amend 30196	**Fee:** $130.20 **Benefit:** 75% = $97.65 85% = $110.70
	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 (See para TN.8.10 of explanatory notes to this Category)
Amend 30202	**Fee:** $49.85 **Benefit:** 75% = $37.40 85% = $42.40
	Skin lesions, multiple injections with glucocorticoid preparations (Anaes.)
30207	**Fee:** $46.00 **Benefit:** 75% = $34.50 85% = $39.10
	Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparations, if undertaken in the operating theatre of a hospital on a patient less than 16 years of age (Anaes.)
30210	**Fee:** $168.05 **Benefit:** 75% = $126.05
	HAEMATOMA, aspiration of (Anaes.)
30216	**Fee:** $28.20 **Benefit:** 75% = $21.15 85% = $24.00
	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare) (See para TN.8.4 of explanatory notes to this Category)
30219	**Fee:** $28.20 **Benefit:** 75% = $21.15 85% = $24.00

30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $168.05 **Benefit:** 75% = $126.05
30224	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $245.00 **Benefit:** 75% = $183.75 85% = $208.25
30225	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $276.05 **Benefit:** 75% = $207.05 85% = $234.65
30226	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.) **Fee:** $154.45 **Benefit:** 75% = $115.85 85% = $131.30
30229	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.) **Fee:** $281.45 **Benefit:** 75% = $211.10 85% = $239.25
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $230.60 **Benefit:** 75% = $172.95 85% = $196.05
30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) **Fee:** $304.95 **Benefit:** 75% = $228.75 85% = $259.25
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.) **Fee:** $154.45 **Benefit:** 75% = $115.85 85% = $131.30
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65 85% = $312.40
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $711.35 **Benefit:** 75% = $533.55
30247	PAROTID GLAND, total extirpation of (Anaes.) (Assist.) **Fee:** $762.45 **Benefit:** 75% = $571.85
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.) **Fee:** $1,290.15 **Benefit:** 75% = $967.65
30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.) **Fee:** $1,981.80 **Benefit:** 75% = $1486.35 85% = $1897.10
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.) **Fee:** $860.10 **Benefit:** 75% = $645.10

30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $1,145.35 **Benefit:** 75% = $859.05
30256	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) **Fee:** $459.35 **Benefit:** 75% = $344.55
30259	SUBLINGUAL GLAND, extirpation of (Anaes.) **Fee:** $204.75 **Benefit:** 75% = $153.60 85% = $174.05
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $60.65 **Benefit:** 75% = $45.50 85% = $51.60
30266	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) **Fee:** $154.45 **Benefit:** 75% = $115.85 85% = $131.30
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) **Fee:** $154.45 **Benefit:** 75% = $115.85 85% = $131.30
30272	TONGUE, partial excision of (Anaes.) (Assist.) **Fee:** $304.95 **Benefit:** 75% = $228.75 85% = $259.25
30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH NODES OF NECK (commandotype operation) (Anaes.) (Assist.) **Fee:** $1,817.80 **Benefit:** 75% = $1363.35
30278	TONGUE TIE, repair of, not being a service to which another item in this Group applies (Anaes.) **Fee:** $47.95 **Benefit:** 75% = $36.00 85% = $40.80
30281	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.) **Fee:** $123.20 **Benefit:** 75% = $92.40 85% = $104.75
30283	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $211.10 **Benefit:** 75% = $158.35 85% = $179.45
30286	BRANCHIAL CYST, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.) **Fee:** $410.25 **Benefit:** 75% = $307.70 85% = $348.75
30287	BRANCHIAL CYST, on a person under 10 years of age. Removal of, (Anaes.) (Assist.) **Fee:** $533.40 **Benefit:** 75% = $400.05 85% = $453.40
30289	BRANCHIAL FISTULA, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.) **Fee:** $517.95 **Benefit:** 75% = $388.50
30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.) **Fee:** $459.35 **Benefit:** 75% = $344.55 85% = $390.45
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic

	reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) **Fee:** $1,817.80 **Benefit:** 75% = $1363.35
30296	THYROIDECTOMY, total (Anaes.) (Assist.) (See para TN.8.137 of explanatory notes to this Category) **Fee:** $1,055.70 **Benefit:** 75% = $791.80
30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) (See para TN.8.138 of explanatory notes to this Category) **Fee:** $1,055.70 **Benefit:** 75% = $791.80
30299	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) (Assist.) (See para TN.8.12 of explanatory notes to this Category) **Fee:** $657.35 **Benefit:** 75% = $493.05
30300	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30299, 30302 or 30303 applies (Anaes.) (Assist.) (See para TN.8.12 of explanatory notes to this Category) **Fee:** $788.80 **Benefit:** 75% = $591.60
30302	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30303 applies (Anaes.) (Assist.) (See para TN.8.12 of explanatory notes to this Category) **Fee:** $525.85 **Benefit:** 75% = $394.40
30303	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30302 applies (Anaes.) (Assist.) (See para TN.8.12 of explanatory notes to this Category) **Fee:** $630.95 **Benefit:** 75% = $473.25
30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) (See para TN.8.137, TN.8.138 of explanatory notes to this Category) **Fee:** $823.60 **Benefit:** 75% = $617.70
30310	Partial or subtotal thyroidectomy (Anaes.) (Assist.) (See para TN.8.137 of explanatory notes to this Category) **Fee:** $823.60 **Benefit:** 75% = $617.70
30314	THYROGLOSSAL CYST or FISTULA or both, on a person 10 years of age or over. Radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.) **Fee:** $471.65 **Benefit:** 75% = $353.75
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:** $1,175.50 **Benefit:** 75% = $881.65
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:** $1,407.55 **Benefit:** 75% = $1055.70
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:** $1,175.50 **Benefit:** 75% = $881.65
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:** $1,407.55 **Benefit:** 75% = $1055.70
30323	Excision of phaeochromocytoma or extraadrenal paraganglioma via endoscopic or open approach. (Anaes.) (Assist.) **Fee:** $1,407.55 **Benefit:** 75% = $1055.70
30324	Excision of an adrenocortical tumour or hyperplasia via endoscopic or open approach. (Anaes.) (Assist.) **Fee:** $1,407.55 **Benefit:** 75% = $1055.70
30326	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $613.15 **Benefit:** 75% = $459.90
30329	LYMPH NODES of GROIN, limited excision of (Anaes.) **Fee:** $254.65 **Benefit:** 75% = $191.00 85% = $216.50
30330	LYMPH NODES of GROIN, radical excision of (Anaes.) (Assist.) **Fee:** $741.20 **Benefit:** 75% = $555.90
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.) **Fee:** $357.60 **Benefit:** 75% = $268.20
30335	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.) (See para TN.8.13 of explanatory notes to this Category) **Fee:** $893.90 **Benefit:** 75% = $670.45

30336	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.) (See para TN.8.13 of explanatory notes to this Category) **Fee:** $1,072.75 **Benefit:** 75% = $804.60
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $498.35 **Benefit:** 75% = $373.80
30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, on a person 10 years of age or over. Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas (Anaes.) (Assist.) (See para TN.8.14 of explanatory notes to this Category) **Fee:** $537.55 **Benefit:** 75% = $403.20
30376	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $537.55 **Benefit:** 75% = $403.20
30378	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $540.10 **Benefit:** 75% = $405.10
30379	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.) (Assist.) **Fee:** $957.15 **Benefit:** 75% = $717.90
30382	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.) **Fee:** $1,347.70 **Benefit:** 75% = $1010.80
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.) **Fee:** $1,133.75 **Benefit:** 75% = $850.35
30385	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $580.90 **Benefit:** 75% = $435.70
30387	LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including pelvic viscera), not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $654.85 **Benefit:** 75% = $491.15
30388	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.) **Fee:** $1,647.45 **Benefit:** 75% = $1235.60
30390	LAPAROSCOPY, diagnostic, not being a service associated with any other laparoscopic procedure, on a person 10 years of age or over (Anaes.) (See para TN.8.15 of explanatory notes to this Category)

	Fee: $226.80 **Benefit:** 75% = $170.10
30391	LAPAROSCOPY with biopsy (Anaes.) (Assist.) **Fee:** $293.25 **Benefit:** 75% = $219.95
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) **Fee:** $695.60 **Benefit:** 75% = $521.70
30393	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) **Fee:** $540.10 **Benefit:** 75% = $405.10
30394	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Anaes.) (Assist.) **Fee:** $508.25 **Benefit:** 75% = $381.20
30396	LAPAROTOMY for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision, with or without closure of abdomen and with or without mesh or zipper insertion (Anaes.) (Assist.) (See para TN.8.16 of explanatory notes to this Category) **Fee:** $1,048.30 **Benefit:** 75% = $786.25
30397	LAPAROSTOMY, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (Anaes.) **Fee:** $239.60 **Benefit:** 75% = $179.70
30399	LAPAROSTOMY, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (Anaes.) (Assist.) **Fee:** $329.55 **Benefit:** 75% = $247.20
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) **Fee:** $652.25 **Benefit:** 75% = $489.20
30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.) **Fee:** $479.15 **Benefit:** 75% = $359.40
30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or without mesh (Anaes.) (Assist.) **Fee:** $537.55 **Benefit:** 75% = $403.20
30405	VENTRAL OR INCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.) **Fee:** $943.55 **Benefit:** 75% = $707.70
30406	PARACENTESIS ABDOMINIS (Anaes.) **Fee:** $53.85 **Benefit:** 75% = $40.40 85% = $45.80
30408	PERITONEOVENOUS shunt, insertion of (Anaes.) (Assist.)

	Fee: $404.35 **Benefit:** 75% = $303.30
30409	LIVER BIOPSY, percutaneous (Anaes.) **Fee:** $179.90 **Benefit:** 75% = $134.95 85% = $152.95
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) **Fee:** $91.55 **Benefit:** 75% = $68.70
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) **Fee:** $54.00 **Benefit:** 75% = $40.50 85% = $45.90
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.) **Fee:** $711.35 **Benefit:** 75% = $533.55
30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,422.55 **Benefit:** 75% = $1066.95
30416	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.) **Fee:** $772.35 **Benefit:** 75% = $579.30
30417	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.) **Fee:** $1,158.45 **Benefit:** 75% = $868.85
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,647.45 **Benefit:** 75% = $1235.60
30419	LIVER TUMOURS, destruction of, by hepatic cryotherapy, not being a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.) **Fee:** $842.60 **Benefit:** 75% = $631.95 85% = $757.90
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.) (Assist.) **Fee:** $2,058.95 **Benefit:** 75% = $1544.25
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) **Fee:** $696.45 **Benefit:** 75% = $522.35
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) **Fee:** $1,347.70 **Benefit:** 75% = $1010.80
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.) **Fee:** $1,609.75 **Benefit:** 75% = $1207.35
30428	LIVER, lobectomy of, for trauma (Anaes.) (Assist.) **Fee:** $1,722.15 **Benefit:** 75% = $1291.65 85% = $1637.45

	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.)
30430	**Fee:** $2,395.85 **Benefit:** 75% = $1796.90 85% = $2311.15
	LIVER ABSCESS, open abdominal drainage of (Anaes.) (Assist.)
30431	**Fee:** $537.55 **Benefit:** 75% = $403.20 85% = $456.95
	LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.)
30433	**Fee:** $748.70 **Benefit:** 75% = $561.55
	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.) (Assist.)
30434	**Fee:** $606.50 **Benefit:** 75% = $454.90
	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.)
30436	**Fee:** $673.85 **Benefit:** 75% = $505.40
	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.) (Assist.)
30437	**Fee:** $838.70 **Benefit:** 75% = $629.05
	HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.)
30438	**Fee:** $1,186.80 **Benefit:** 75% = $890.10 85% = $1102.10
	OPERATIVE CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA OPERATIVE ULTRASOUND of the biliary tract (including 1 or more examinations performed during the 1 operation) (Anaes.) (Assist.)
30439	**Fee:** $191.40 **Benefit:** 75% = $143.55
	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.)
30440	**Fee:** $542.80 **Benefit:** 75% = $407.10 85% = $461.40
	INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.)
30441	**Fee:** $140.55 **Benefit:** 75% = $105.45
	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.)
30442	**Fee:** $191.40 **Benefit:** 75% = $143.55
	CHOLECYSTECTOMY (Anaes.) (Assist.)
30443	**Fee:** $762.45 **Benefit:** 75% = $571.85
	LAPAROSCOPIC CHOLECYSTECTOMY (Anaes.) (Assist.)
30445	**Fee:** $762.45 **Benefit:** 75% = $571.85
	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.) (Assist.)
30446	**Fee:** $762.45 **Benefit:** 75% = $571.85

	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.)
30448	**Fee:** $1,003.30 **Benefit:** 75% = $752.50
	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.)
30449	**Fee:** $1,115.65 **Benefit:** 75% = $836.75
	Calculus of biliary or renal tract, extraction of, using interventional imaging techniques - other than a service associated with a service to which items 36627 or 36645 applies (Anaes.) (Assist.)
30450	**Fee:** $540.80 **Benefit:** 75% = $405.60 85% = $459.70
	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.)
30451	**Fee:** $276.05 **Benefit:** 75% = $207.05 85% = $234.65
	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.)
30452	**Fee:** $389.30 **Benefit:** 75% = $292.00
	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.) (Assist.)
30454	**Fee:** $889.45 **Benefit:** 75% = $667.10
	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.)
30455	**Fee:** $1,045.70 **Benefit:** 75% = $784.30
	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.)
30457	**Fee:** $1,422.55 **Benefit:** 75% = $1066.95 85% = $1337.85
	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.) (Assist.)
30458	**Fee:** $1,045.70 **Benefit:** 75% = $784.30
	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.)
30460	**Fee:** $889.45 **Benefit:** 75% = $667.10
	RADICAL RESECTION of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.) (Assist.)
30461	**Fee:** $1,524.60 **Benefit:** 75% = $1143.45
	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.) (Assist.)
30463	**Fee:** $1,871.90 **Benefit:** 75% = $1403.95

30464	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Anaes.) (Assist.) **Fee:** $2,246.30 **Benefit:** 75% = $1684.75
30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,295.30 **Benefit:** 75% = $971.50
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,602.25 **Benefit:** 75% = $1201.70
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.) **Fee:** $1,774.70 **Benefit:** 75% = $1331.05 85% = $1690.00
30472	HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Anaes.) (Assist.) **Fee:** $958.35 **Benefit:** 75% = $718.80 85% = $873.65
30473	Oesophagoscopy (not being a service to which item 41816 or 41822 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30478 or 30479 applies. (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $182.65 **Benefit:** 75% = $137.00 85% = $155.30
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:** $359.85 **Benefit:** 75% = $269.90 85% = $305.90
30478	Oesophagoscopy (other than a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy, panendoscopy or push enteroscopy, one or more such procedures, if: (a) the procedures are performed using one or more of the following endoscopic procedures: (i) polypectomy; (ii) sclerosing or adrenalin injections; (iii) banding; (iv) endoscopic clips; (v) haemostatic powders; (vi) diathermy; (vii) argon plasma coagulation; and (b) the procedures are for the treatment of one or more of the following:

	(i) upper gastrointestinal tract bleeding; (ii) polyps; (iii) removal of foreign body; (iv) oesophageal or gastric varices; (v) peptic ulcers; (vi) neoplasia; (vii) benign vascular lesions; (viii) strictures of the gastrointestinal tract; (ix) tumorous overgrowth through or over oesophageal stents; other than a service associated with a service to which item 30473 or 30479 applies (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $253.25 **Benefit:** 75% = $189.95 85% = $215.30
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:** $490.95 **Benefit:** 75% = $368.25 85% = $417.35
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:** $368.15 **Benefit:** 75% = $276.15 85% = $312.95

	PERCUTANEOUS GASTROSTOMY (repeat procedure): (a) including any associated imaging services; and (b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)
30482	**Fee:** $261.75 **Benefit:** 75% = $196.35 85% = $222.50
	GASTROSTOMY BUTTON, CAECOSTOMY ANTEGRADE ENEMA DEVICE (CHAIT etc.) or STOMAL INDWELLING DEVICE: (a) non-endoscopic insertion of; or (b) non-endoscopic replacement of; on a person 10 years of age or over, excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)
30483	**Fee:** $182.60 **Benefit:** 75% = $136.95 85% = $155.25
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.) (See para TN.8.17 of explanatory notes to this Category)
30484	**Fee:** $376.30 **Benefit:** 75% = $282.25 85% = $319.90
	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.) (See para TN.8.17 of explanatory notes to this Category)
30485	**Fee:** $580.90 **Benefit:** 75% = $435.70 85% = $496.20
	SMALL BOWEL INTUBATION as an independent procedure (Anaes.)
30488	**Fee:** $92.80 **Benefit:** 75% = $69.60 85% = $78.90
	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.) (See para TN.8.17 of explanatory notes to this Category)
30490	**Fee:** $542.80 **Benefit:** 75% = $407.10 85% = $461.40
	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.) (See para TN.8.17 of explanatory notes to this Category)
30491	**Fee:** $572.70 **Benefit:** 75% = $429.55 85% = $488.00
	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.)
30492	**Fee:** $811.90 **Benefit:** 75% = $608.95
	ENDOSCOPIC BILIARY DILATATION (Anaes.) (See para TN.8.17 of explanatory notes to this Category)
30494	**Fee:** $433.65 **Benefit:** 75% = $325.25
	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.)
30495	**Fee:** $811.90 **Benefit:** 75% = $608.95
	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.)
30496	**Fee:** $606.50 **Benefit:** 75% = $454.90 85% = $521.80

30497	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.) **Fee:** $723.20 **Benefit:** 75% = $542.40
30499	VAGOTOMY, highly selective (Anaes.) (Assist.) **Fee:** $860.10 **Benefit:** 75% = $645.10
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.) **Fee:** $921.00 **Benefit:** 75% = $690.75 85% = $836.30
30502	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.) **Fee:** $1,016.45 **Benefit:** 75% = $762.35
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.) **Fee:** $1,138.25 **Benefit:** 75% = $853.70 85% = $1053.55
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.) (Assist.) **Fee:** $569.10 **Benefit:** 75% = $426.85
30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.) **Fee:** $995.90 **Benefit:** 75% = $746.95
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.) (Assist.) **Fee:** $1,048.30 **Benefit:** 75% = $786.25
30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.) **Fee:** $1,048.30 **Benefit:** 75% = $786.25 85% = $963.60
30515	Gastroenterostomy (including gastroduodenostomy) or enterocolostomy or enteroenterostomy, not being a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) **Fee:** $726.35 **Benefit:** 75% = $544.80
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes.) (Assist.) **Fee:** $951.00 **Benefit:** 75% = $713.25
30518	Partial gastrectomy, not being a service associated with a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) **Fee:** $1,018.35 **Benefit:** 75% = $763.80
30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes.) (Assist.) **Fee:** $696.45 **Benefit:** 75% = $522.35
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) **Fee:** $1,490.00 **Benefit:** 75% = $1117.50

30523	GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes.) (Assist.) (See para TN.8.18 of explanatory notes to this Category) **Fee:** $1,557.25 **Benefit:** 75% = $1167.95
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.) **Fee:** $1,714.60 **Benefit:** 75% = $1285.95
30526	GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist.) **Fee:** $2,223.70 **Benefit:** 75% = $1667.80
30527	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $898.55 **Benefit:** 75% = $673.95
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:** $1,347.70 **Benefit:** 75% = $1010.80
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $808.70 **Benefit:** 75% = $606.55
30532	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $928.55 **Benefit:** 75% = $696.45
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:** $1,104.45 **Benefit:** 75% = $828.35
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.) **Fee:** $1,749.65 **Benefit:** 75% = $1312.25
30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,774.70 **Benefit:** 75% = $1331.05
30538	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,228.00 **Benefit:** 75% = $921.00
30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and

	anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.) **Fee:** $898.55 **Benefit:** 75% = $673.95
30541	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,564.95 **Benefit:** 75% = $1173.75
30542	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,063.30 **Benefit:** 75% = $797.50
30544	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.) **Fee:** $778.80 **Benefit:** 75% = $584.10
30545	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,894.50 **Benefit:** 75% = $1420.90
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,302.80 **Benefit:** 75% = $977.10 85% = $1218.10
30548	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.) **Fee:** $973.30 **Benefit:** 75% = $730.00 85% = $888.60
30550	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes.) (Assist.) **Fee:** $2,126.65 **Benefit:** 75% = $1595.00
30551	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,467.60 **Benefit:** 75% = $1100.70
30553	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,085.55 **Benefit:** 75% = $814.20 85% = $1000.85
30554	OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.) **Fee:** $2,366.10 **Benefit:** 75% = $1774.60
30556	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,632.20 **Benefit:** 75% = $1224.15
30557	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,205.50 **Benefit:** 75% = $904.15

	OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.)
30559	**Fee:** $876.10 **Benefit:** 75% = $657.10 85% = $791.40
	OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.)
30560	**Fee:** $973.30 **Benefit:** 75% = $730.00
	ENTEROSTOMY or COLOSTOMY, closure of (not involving resection of bowel), on a person 10 years of age or over (Anaes.) (Assist.)
30562	**Fee:** $613.55 **Benefit:** 75% = $460.20
	COLOSTOMY OR ILEOSTOMY, refashioning of, on a person 10 years of age or over (Anaes.) (Assist.)
30563	**Fee:** $613.55 **Benefit:** 75% = $460.20 85% = $528.85
	SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.)
30564	**Fee:** $796.40 **Benefit:** 75% = $597.30
	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.)
30565	**Fee:** $898.55 **Benefit:** 75% = $673.95
	SMALL INTESTINE, resection of, with anastomosis, on a person 10 years of age or over (Anaes.) (Assist.)
30566	**Fee:** $998.10 **Benefit:** 75% = $748.60
	INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.) (Assist.)
30568	**Fee:** $748.70 **Benefit:** 75% = $561.55
	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (Anaes.) (Assist.)
30569	**Fee:** $381.75 **Benefit:** 75% = $286.35
	APPENDICECTOMY, not being a service to which item 30574 applies on a person 10 years of age or over (Anaes.) (Assist.)
30571	**Fee:** $459.35 **Benefit:** 75% = $344.55
	LAPAROSCOPIC APPENDICECTOMY, on a person 10 years of age or over (Anaes.) (Assist.)
30572	**Fee:** $459.35 **Benefit:** 75% = $344.55
	NOTE: *Multiple Operation and Multiple Anaesthetic rules apply to this item* APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.)
30574	**Fee:** $127.10 **Benefit:** 75% = $95.35
	PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes.) (Assist.)
30575	**Fee:** $528.70 **Benefit:** 75% = $396.55
30577	PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION

	requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.) **Fee:** $1,123.20 **Benefit:** 75% = $842.40
30578	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.) (Assist.) **Fee:** $1,183.05 **Benefit:** 75% = $887.30
30580	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.) (Assist.) **Fee:** $1,078.10 **Benefit:** 75% = $808.60
30581	ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.) (Assist.) **Fee:** $786.15 **Benefit:** 75% = $589.65
30583	DISTAL PANCREATECTOMY (Anaes.) (Assist.) **Fee:** $1,231.55 **Benefit:** 75% = $923.70
30584	PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes.) (Assist.) **Fee:** $1,817.80 **Benefit:** 75% = $1363.35
30586	PANCREATIC CYST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic means (Anaes.) (Assist.) **Fee:** $723.20 **Benefit:** 75% = $542.40
30587	PANCREATIC CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.) **Fee:** $748.70 **Benefit:** 75% = $561.55
30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.) **Fee:** $1,290.15 **Benefit:** 75% = $967.65
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.) **Fee:** $1,422.55 **Benefit:** 75% = $1066.95
30593	PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.) **Fee:** $1,946.70 **Benefit:** 75% = $1460.05 85% = $1862.00
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.) **Fee:** $2,246.30 **Benefit:** 75% = $1684.75
30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.) **Fee:** $925.30 **Benefit:** 75% = $694.00
30597	SPLENECTOMY (Anaes.) (Assist.) **Fee:** $742.70 **Benefit:** 75% = $557.05
30599	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal

	incision (Anaes.) (Assist.) **Fee:** $1,347.70 **Benefit:** 75% = $1010.80
30600	DIAPHRAGMATIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.) **Fee:** $801.40 **Benefit:** 75% = $601.05
30601	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 person 10 years of age or over (Anaes.) (Assist.) **Fee:** $987.20 **Benefit:** 75% = $740.40
30602	PORTAL HYPERTENSION, porto-caval shunt for (Anaes.) (Assist.) **Fee:** $1,602.25 **Benefit:** 75% = $1201.70
30603	PORTAL HYPERTENSION, meso-caval shunt for (Anaes.) (Assist.) **Fee:** $1,692.15 **Benefit:** 75% = $1269.15 85% = $1607.45
30605	PORTAL HYPERTENSION, selective spleno-renal shunt for (Anaes.) (Assist.) **Fee:** $1,924.25 **Benefit:** 75% = $1443.20
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.) **Fee:** $1,145.50 **Benefit:** 75% = $859.15
30608	SMALL INTESTINE, resection of, with anastomosis, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $1,297.55 **Benefit:** 75% = $973.20
30609	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30614 applies (Anaes.) (Assist.) **Fee:** $479.05 **Benefit:** 75% = $359.30
30611	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata - removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person under 10 years of age , not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $580.95 **Benefit:** 75% = $435.75 85% = $496.25
30614	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $479.05 **Benefit:** 75% = $359.30
30615	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $537.55 **Benefit:** 75% = $403.20
30618	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a person under 10 years of age (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $538.55 **Benefit:** 75% = $403.95 85% = $457.80

30619	LAPAROSCOPIC SPLENECTOMY, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $965.50 **Benefit:** 75% = $724.15
30621	Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or other formal repair of, in a person 10 years of age or over, other than a service to which item 30403 or 30405 applies (Anaes.) (Assist.) **Fee:** $420.20 **Benefit:** 75% = $315.15
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 person under 10 years of age (Anaes.) (Assist.) (See para TN.8.14 of explanatory notes to this Category) **Fee:** $698.85 **Benefit:** 75% = $524.15
30623	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $698.85 **Benefit:** 75% = $524.15
30626	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $702.10 **Benefit:** 75% = $526.60
30627	LAPAROSCOPY, diagnostic, not being a service associated with any other laparoscopic procedure, on a person under 10 years of age (Anaes.) (See para TN.8.15 of explanatory notes to this Category) **Fee:** $294.90 **Benefit:** 75% = $221.20
30628	HYDROCELE, tapping of **Fee:** $36.70 **Benefit:** 75% = $27.55 85% = $31.20
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:** $537.55 **Benefit:** 75% = $403.20
Fee 30630	Insertion of testicular prosthesis, at least 6 months following orchidectomy (Anaes.) (Assist.) **Fee:** $488.55 **Benefit:** 75% = $366.45
30631	Hydrocele, removal of, other than a service associated with a service to which item 30641, 30642 or 30644 applies (Anaes.) **Fee:** $244.05 **Benefit:** 75% = $183.05 85% = $207.45
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:** $300.90 **Benefit:** 75% = $225.70

	GASTROSTOMY BUTTON, caecostomy antegrade enema device (chait etc) and/or stomal indwelling device, non-endoscopic insertion of, or non-endoscopic replacement of, on a person under 10 years of age (Anaes.)
30636	**Fee:** $240.45 **Benefit:** 75% = $180.35 85% = $204.40
	ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel, on a person under 10 years of age (Anaes.) (Assist.)
30637	**Fee:** $797.70 **Benefit:** 75% = $598.30
	COLOSTOMY OR ILEOSTOMY, refashioning of, on a person under 10 years of age (Anaes.) (Assist.)
30639	**Fee:** $797.70 **Benefit:** 75% = $598.30 85% = $713.00
	Repair of large and irreducible scrotal hernia, where duration of surgery exceeds 2 hours, in a person 10 years of age or over, other than a service to which item 30403, 30405, 30614, 30615 or 30621 applies (Anaes.) (Assist.)
30640	**Fee:** $943.55 **Benefit:** 75% = $707.70
	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes.) (Assist.)
30641	**Fee:** $420.20 **Benefit:** 75% = $315.15
	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.)
30642	**Fee:** $781.85 **Benefit:** 75% = $586.40
	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.)
30643	**Fee:** $698.85 **Benefit:** 75% = $524.15
	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.)
30644	**Fee:** $537.55 **Benefit:** 75% = $403.20
	APPENDICECTOMY, not being a service to which item 30574 applies, on a person under 10 years of age (Anaes.) (Assist.)
30645	**Fee:** $597.05 **Benefit:** 75% = $447.80
	LAPAROSCOPIC APPENDICECTOMY, on a person under 10 years of age (Anaes.) (Assist.)
30646	**Fee:** $597.05 **Benefit:** 75% = $447.80
	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia on a person under 10 years of age (Anaes.)
30649	**Fee:** $193.50 **Benefit:** 75% = $145.15 85% = $164.50
	Circumcision of the penis, with topical or local analgesia, other than a service to which item 30658 applies
30654	**Fee:** $47.95 **Benefit:** 75% = $36.00 85% = $40.80

	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.)
30658	**Fee:** $146.40 **Benefit:** 75% = $109.80 85% = $124.45
	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia on a person 10 years of age or over (Anaes.)
30663	**Fee:** $148.85 **Benefit:** 75% = $111.65 85% = $126.55
	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.)
30666	**Fee:** $48.90 **Benefit:** 75% = $36.70 85% = $41.60
	COCCYX, excision of (Anaes.) (Assist.)
30672	**Fee:** $459.35 **Benefit:** 75% = $344.55
	PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.)
30676	**Fee:** $390.90 **Benefit:** 75% = $293.20 85% = $332.30
	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.)
30679	**Fee:** $99.30 **Benefit:** 75% = $74.50 85% = $84.45
	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.) (See para TN.8.17 of explanatory notes to this Category)
30680	**Fee:** $1,206.55 **Benefit:** 75% = $904.95 85% = $1121.85
	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
30682	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify

	the cause of the bleeding. (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,206.55 **Benefit:** 75% = $904.95 85% = $1121.85
30684	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,484.85 **Benefit:** 75% = $1113.65 85% = $1400.15
30686	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,484.85 **Benefit:** 75% = $1113.65 85% = $1400.15
30687	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.) (See para TN.8.17, TN.8.20 of explanatory notes to this Category) **Fee:** $490.95 **Benefit:** 75% = $368.25 85% = $417.35
30688	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this

	Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) (See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $376.30 **Benefit:** 75% = $282.25 85% = $319.90
30690	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.) (See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $580.90 **Benefit:** 75% = $435.70 85% = $496.20
30692	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.) (See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $376.30 **Benefit:** 75% = $282.25 85% = $319.90
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:** $580.90 **Benefit:** 75% = $435.70 85% = $496.20
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:** $599.05 **Benefit:** 75% = $449.30 85% = $514.35
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:** $748.70 **Benefit:** 75% = $561.55 85% = $664.00
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:** $898.55 **Benefit:** 75% = $673.95 85% = $813.85
31003	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer

	sections Not applicable to a service performed in association with a service to which item 31000 applies (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $599.05 **Benefit:** 75% = $449.30 85% = $514.35
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:** $748.70 **Benefit:** 75% = $561.55 85% = $664.00
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:** $898.55 **Benefit:** 75% = $673.95 85% = $813.85
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:** $98.45 **Benefit:** 75% = $73.85 85% = $83.70
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:** $126.95 **Benefit:** 75% = $95.25 85% = $107.95
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:** $148.05 **Benefit:** 75% = $111.05 85% = $125.85

31220	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if: (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:** $221.25 **Benefit:** 75% = $165.95 85% = $188.10
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:** $221.25 **Benefit:** 75% = $165.95 85% = $188.10
31225	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.) **Fee:** $393.20 **Benefit:** 75% = $294.90 85% = $334.25
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:** $380.50 **Benefit:** 75% = $285.40 85% = $323.45
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:** $380.50 **Benefit:** 75% = $285.40 85% = $323.45
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 or 31376 is excised (Anaes.) **Derived Fee:** 75% of the fee for excision of malignant tumour
31345	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and 50mm or more in diameter, or is sub-fascial, *where the specimen is sent for histological confirmation of diagnosis* (Anaes.) **Fee:** $217.55 **Benefit:** 75% = $163.20 85% = $184.95
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:** $217.55 **Benefit:** 75% = $163.20 85% = $184.95
31350	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person 10 years of age or over, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $446.90 **Benefit:** 75% = $335.20 85% = $379.90
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:** $736.80 **Benefit:** 75% = $552.60 85% = $652.10
31356	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $228.25 **Benefit:** 75% = $171.20 85% = $194.05
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:** $113.10 **Benefit:** 75% = $84.85 85% = $96.15
31358	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $279.35 **Benefit:** 75% = $209.55 85% = $237.45
31359	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia (the applicable site); and (b) the necessary excision area is at least one third of the surface area of the applicable site; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (H) (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $340.50 **Benefit:** 75% = $255.40
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:** $173.30 **Benefit:** 75% = $130.00 85% = $147.35
31361	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:

	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $192.55 **Benefit:** 75% = $144.45 85% = $163.70
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:** $138.10 **Benefit:** 75% = $103.60 85% = $117.40
31363	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $251.90 **Benefit:** 75% = $188.95 85% = $214.15
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:** $173.30 **Benefit:** 75% = $130.00 85% = $147.35
31365	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372 or 31373), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $163.25 **Benefit:** 75% = $122.45 85% = $138.80
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:** $98.45 **Benefit:** 75% = $73.85 85% = $83.70
31367	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $220.25 **Benefit:** 75% = $165.20 85% = $187.25

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:** $129.45 **Benefit:** 75% = $97.10 85% = $110.05
31369	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $253.60 **Benefit:** 75% = $190.20 85% = $215.60
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:** $148.05 **Benefit:** 75% = $111.05 85% = $125.85
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, 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: $368.15 **Benefit:** 75% = $276.15 85% = $312.95
31372	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (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 item 45201 (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $318.35 **Benefit:** 75% = $238.80 85% = $270.60
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, 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:** $367.95 **Benefit:** 75% = $276.00 85% = $312.80
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, 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 item 45201 (Anaes.) (See para TN.8.125, TN.1.21 of explanatory notes to this Category) **Fee:** $290.70 **Benefit:** 75% = $218.05 85% = $247.10
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, 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 item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $312.85 **Benefit:** 75% = $234.65 85% = $265.95
31376	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from 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.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $362.60 **Benefit:** 75% = $271.95 85% = $308.25
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:** $269.25 **Benefit:** 75% = $201.95 85% = $228.90
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:** $310.75 **Benefit:** 75% = $233.10
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:** $517.85 **Benefit:** 75% = $388.40 85% = $440.20
31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,608.90 **Benefit:** 75% = $1206.70
31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,981.80 **Benefit:** 75% = $1486.35
31420	LYMPH NODE OF NECK, biopsy of (Anaes.) **Fee:** $189.65 **Benefit:** 75% = $142.25 85% = $161.25
31423	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a person 10 years of age or over (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $414.30 **Benefit:** 75% = $310.75 85% = $352.20

	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category)
31426	**Fee:** $828.55 **Benefit:** 75% = $621.45
	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category)
31429	**Fee:** $1,291.25 **Benefit:** 75% = $968.45
	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category)
31432	**Fee:** $1,381.00 **Benefit:** 75% = $1035.75
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category)
31435	**Fee:** $1,015.05 **Benefit:** 75% = $761.30
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category)
31438	**Fee:** $1,608.90 **Benefit:** 75% = $1206.70
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes.) (Assist.)
31450	**Fee:** $419.35 **Benefit:** 75% = $314.55
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.)
31452	**Fee:** $733.75 **Benefit:** 75% = $550.35
	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.)
31454	**Fee:** $580.90 **Benefit:** 75% = $435.70
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.)
31456	**Fee:** $253.25 **Benefit:** 75% = $189.95
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.)
31458	**Fee:** $303.85 **Benefit:** 75% = $227.90
	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.)
31460	**Fee:** $368.15 **Benefit:** 75% = $276.15
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal

	resection (Anaes.) (Assist.) **Fee:** $537.55 **Benefit:** 75% = $403.20
31464	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $898.55 **Benefit:** 75% = $673.95
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:** $1,347.75 **Benefit:** 75% = $1010.85
31468	PARA-OESOPHAGEAL HIATUS HERNIA, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Anaes.) (Assist.) **Fee:** $1,480.70 **Benefit:** 75% = $1110.55
31470	LAPAROSCOPIC SPLENECTOMY, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $742.70 **Benefit:** 75% = $557.05
31472	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes.) (Assist.) **Fee:** $1,206.35 **Benefit:** 75% = $904.80
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:** $268.15 **Benefit:** 75% = $201.15 85% = $227.95
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:** $357.60 **Benefit:** 75% = $268.20 85% = $304.00
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:** $402.30 **Benefit:** 75% = $301.75
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:** $357.60 **Benefit:** 75% = $268.20 85% = $304.00
31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.) **Fee:** $670.45 **Benefit:** 75% = $502.85
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:** $449.80 **Benefit:** 75% = $337.35
Amend 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:** $894.05 **Benefit:** 75% = $670.55
31519	BREAST, total mastectomy (H) (Anaes.) (Assist.) **Fee:** $759.05 **Benefit:** 75% = $569.30
31524	BREAST, subcutaneous mastectomy (H) (Anaes.) (Assist.) **Fee:** $1,072.75 **Benefit:** 75% = $804.60
31525	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.) **Fee:** $536.20 **Benefit:** 75% = $402.15
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:** $614.30 **Benefit:** 75% = $460.75 85% = $529.60
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:** $142.20 **Benefit:** 75% = $106.65 85% = $120.90
31536	Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques, but not including imaging (Anaes.) (Anaes.) **Fee:** $195.35 **Benefit:** 75% = $146.55 85% = $166.05
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:** $206.25 **Benefit:** 75% = $154.70 85% = $175.35
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:** $223.50 **Benefit:** 75% = $167.65
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.)

	Fee: $447.05 **Benefit:** 75% = $335.30
31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.) **Fee:** $357.60 **Benefit:** 75% = $268.20 85% = $304.00
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.) **Fee:** $357.60 **Benefit:** 75% = $268.20 85% = $304.00 **Extended Medicare Safety Net Cap:** $286.10
31563	INVERTED NIPPLE, surgical eversion of (Anaes.) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70
31566	ACCESSORY NIPPLE, excision of (Anaes.) **Fee:** $134.05 **Benefit:** 75% = $100.55 85% = $113.95
	BARIATRIC
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:** $876.10 **Benefit:** 75% = $657.10
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:** $1,078.10 **Benefit:** 75% = $808.60
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:** $876.10 **Benefit:** 75% = $657.10
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:** $876.10 **Benefit:** 75% = $657.10
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:** $1,078.10 **Benefit:** 75% = $808.60
31584	Surgical reversal of adjustable gastric banding (removal or replacement of gastric band), gastric bypass, gastroplasty (excluding by gastric plication) or biliopancreatic diversion being services to which items 31569 to 31581 apply (Anaes.) (Assist.) (See para TN.8.30 of explanatory notes to this Category) **Fee:** $1,587.20 **Benefit:** 75% = $1190.40
31587	Adjustment of gastric band as an independent procedure including any associated consultation **Fee:** $101.00 **Benefit:** 75% = $75.75 85% = $85.85

T8. SURGICAL OPERATIONS	1. GENERAL
	Adjustment of gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.)
31590	**Fee:** $259.60 **Benefit:** 75% = $194.70 85% = $220.70

T8. SURGICAL OPERATIONS	2. COLORECTAL
	Group T8. Surgical Operations
	Subgroup 2. Colorectal
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,063.55 **Benefit:** 75% = $797.70
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.) **Fee:** $1,112.50 **Benefit:** 75% = $834.40
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 or 32006 applies (Anaes.) (Assist.) **Fee:** $1,186.30 **Benefit:** 75% = $889.75
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 or 32006 applies (Anaes.) (Assist.) **Fee:** $1,340.15 **Benefit:** 75% = $1005.15
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,186.30 **Benefit:** 75% = $889.75
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.) **Fee:** $1,407.25 **Benefit:** 75% = $1055.45
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) **Fee:** $1,554.45 **Benefit:** 75% = $1165.85
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.) **Fee:** $1,910.40 **Benefit:** 75% = $1432.80
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) **Fee:** $1,619.95 **Benefit:** 75% = $1215.00
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) **Fee:** $580.90 **Benefit:** 75% = $435.70
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:** $572.70 **Benefit:** 75% = $429.55
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 32103, 32104 or 32106 applies (Anaes.) (Assist.) **Fee:** $1,407.25 **Benefit:** 75% = $1055.45
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 32103, 32104 or 32106 applies (Anaes.) (Assist.) **Fee:** $1,882.30 **Benefit:** 75% = $1411.75
32026	RECTUM, ULTRA LOW RESTORATIVE RESECTION, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes.) (Assist.) **Fee:** $2,027.05 **Benefit:** 75% = $1520.30
32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.) **Fee:** $2,172.00 **Benefit:** 75% = $1629.00
32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $434.35 **Benefit:** 75% = $325.80
32030	RECTOSIGMOIDECTOMY (Hartmann's operation) (Anaes.) (Assist.) **Fee:** $1,063.55 **Benefit:** 75% = $797.70
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.) **Fee:** $1,554.45 **Benefit:** 75% = $1165.85
32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) **Fee:** $1,971.55 **Benefit:** 75% = $1478.70
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.) **Fee:** $1,583.00 **Benefit:** 75% = $1187.25
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) **Fee:** $1,333.55 **Benefit:** 75% = $1000.20
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) **Fee:** $499.10 **Benefit:** 75% = $374.35

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:** $771.25 **Benefit:** 75% = $578.45
32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.) **Fee:** $898.55 **Benefit:** 75% = $673.95
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:** $2,388.95 **Benefit:** 75% = $1791.75
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:** $2,192.60 **Benefit:** 75% = $1644.45
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) **Fee:** $580.90 **Benefit:** 75% = $435.70
32060	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.) (Assist.) **Fee:** $2,388.95 **Benefit:** 75% = $1791.75
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:** $2,192.60 **Benefit:** 75% = $1644.45
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:** $580.90 **Benefit:** 75% = $435.70
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) **Fee:** $1,767.15 **Benefit:** 75% = $1325.40
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy **Fee:** $49.35 **Benefit:** 75% = $37.05 85% = $41.95
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:** $77.40 **Benefit:** 75% = $58.05 85% = $65.80
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:** $114.85 **Benefit:** 75% = $86.15 85% = $97.65
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:** $211.10 **Benefit:** 75% = $158.35 85% = $179.45
32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $569.10 **Benefit:** 75% = $426.85
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:** $131.80 **Benefit:** 75% = $98.85 85% = $112.05
32096	RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.) **Fee:** $264.95 **Benefit:** 75% = $198.75
32099	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes.) (Assist.) **Fee:** $343.65 **Benefit:** 75% = $257.75
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.) **Fee:** $654.50 **Benefit:** 75% = $490.90
32103	RECTAL TUMOUR, of less than 4 cm in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Anaes.) (Assist.) (See para TN.8.31, TN.8.17 of explanatory notes to this Category) **Fee:** $796.40 **Benefit:** 75% = $597.30
32104	RECTAL TUMOUR, of 4 cm or greater in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Anaes.) (Assist.) (See para TN.8.31, TN.8.17 of explanatory notes to this Category) **Fee:** $1,030.90 **Benefit:** 75% = $773.20
32105	ANORECTAL CARCINOMA per anal full thickness excision of (Anaes.) (Assist.) **Fee:** $499.10 **Benefit:** 75% = $374.35 85% = $424.25
32106	ANTEROLATERAL INTRAPERITONEAL RECTAL TUMOUR, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is

	unable to be performed during colonoscopy and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.) (See para TN.8.31, TN.8.17 of explanatory notes to this Category) **Fee:** $1,407.25 **Benefit:** 75% = $1055.45 85% = $1322.55
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.) **Fee:** $1,030.90 **Benefit:** 75% = $773.20
32111	RECTAL PROLAPSE Delorme procedure for (Anaes.) (Assist.) **Fee:** $654.50 **Benefit:** 75% = $490.90
32112	RECTAL PROLAPSE, perineal recto-sigmoidectomy for (Anaes.) (Assist.) **Fee:** $796.40 **Benefit:** 75% = $597.30
32114	RECTAL STRICTURE, per anal release of (Anaes.) **Fee:** $179.90 **Benefit:** 75% = $134.95 85% = $152.95
32115	RECTAL STRICTURE, dilatation of (Anaes.) **Fee:** $130.85 **Benefit:** 75% = $98.15
32117	RECTAL PROLAPSE, abdominal rectopexy of (Anaes.) (Assist.) **Fee:** $1,030.90 **Benefit:** 75% = $773.20
32120	RECTAL PROLAPSE, perineal repair of (Anaes.) (Assist.) **Fee:** $264.95 **Benefit:** 75% = $198.75
32123	ANAL STRICTURE, anoplasty for (Anaes.) (Assist.) **Fee:** $343.65 **Benefit:** 75% = $257.75 85% = $292.15
32126	ANAL INCONTINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.) **Fee:** $499.10 **Benefit:** 75% = $374.35
32129	ANAL SPHINCTER, direct repair of (Anaes.) (Assist.) **Fee:** $654.50 **Benefit:** 75% = $490.90
32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.) **Fee:** $550.30 **Benefit:** 75% = $412.75
32132	HAEMORRHOIDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.) **Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55
32135	HAEMORRHOIDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.) **Fee:** $69.65 **Benefit:** 75% = $52.25 85% = $59.25
32138	HAEMORRHOIDECTOMY including excision of anal skin tags when performed (Anaes.) **Fee:** $379.25 **Benefit:** 75% = $284.45 85% = $322.40
32139	HAEMORRHOIDECTOMY involving third or fourth degree haemorrhoids, including excision of anal

	skin tags when performed (Anaes.) (Assist.) **Fee:** $379.25 **Benefit:** 75% = $284.45
32142	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of (Anaes.) **Fee:** $69.65 **Benefit:** 75% = $52.25 85% = $59.25
32145	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $139.25 **Benefit:** 75% = $104.45
32147	PERIANAL THROMBOSIS, incision of (Anaes.) **Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55
32150	OPERATION FOR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.) **Fee:** $264.95 **Benefit:** 75% = $198.75 85% = $225.25
32153	ANUS, DILATATION OF, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $72.25 **Benefit:** 75% = $54.20
32156	FISTULA-IN-ANO, SUBCUTANEOUS, excision of (Anaes.) **Fee:** $135.85 **Benefit:** 75% = $101.90 85% = $115.50
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:** $343.65 **Benefit:** 75% = $257.75
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:** $499.10 **Benefit:** 75% = $374.35
32165	ANAL FISTULA, repair of, by mucosal flap advancement (Anaes.) (Assist.) **Fee:** $654.50 **Benefit:** 75% = $490.90 85% = $569.80
32166	ANAL FISTULA - readjustment of Seton (Anaes.) **Fee:** $212.65 **Benefit:** 75% = $159.50 85% = $180.80
32168	FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (Anaes.) **Fee:** $135.85 **Benefit:** 75% = $101.90
32171	ANORECTAL EXAMINATION, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $91.55 **Benefit:** 75% = $68.70
32174	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) **Fee:** $91.55 **Benefit:** 75% = $68.70 85% = $77.85
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating

	theatre of a hospital (excluding aftercare) (Anaes.) **Fee:** $167.75 **Benefit:** 75% = $125.85
32177	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) **Fee:** $179.70 **Benefit:** 75% = $134.80
32180	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) **Fee:** $264.95 **Benefit:** 75% = $198.75
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) **Fee:** $579.20 **Benefit:** 75% = $434.40
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) **Fee:** $579.20 **Benefit:** 75% = $434.40
32200	DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.) **Fee:** $304.95 **Benefit:** 75% = $228.75 85% = $259.25
32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.) **Fee:** $654.85 **Benefit:** 75% = $491.15
32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.) **Fee:** $591.65 **Benefit:** 75% = $443.75
32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.) (Assist.) **Fee:** $950.75 **Benefit:** 75% = $713.10
32210	GRACILIS NEOSPHINCTER PACEMAKER, replacement of (Anaes.) **Fee:** $263.45 **Benefit:** 75% = $197.60 85% = $223.95
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:** $140.55 **Benefit:** 75% = $105.45
32213	Sacral nerve lead or leads, percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or

	d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) **Fee:** $681.60 **Benefit:** 75% = $511.20
32214	Neurostimulator or receiver, subcutaneous placement of, involving placement and connection of an extension wire to a sacral nerve electrode using fluoroscopic guidance, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) (Assist.) **Fee:** $344.45 **Benefit:** 75% = $258.35
32215	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who: a) is medically unfit for surgery; or b) is pregnant or planning pregnancy; or

	c) has irritable bowel syndrome; or d) has congenital anorectal malformations; or e) has active anal abscesses or fistulas; or f) has anorectal organic bowel disease, including cancer; or g) has functional effects of previous pelvic irradiation; or h) has congenital or acquired malformations of the sacrum; or i) has had rectal or anal surgery within the previous 12 months –each day **Fee:** $129.30 **Benefit:** 75% = $97.00 85% = $109.95
32216	Sacral nerve lead or leads, percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning of) and interoperative test stimulation, to correct displacement or unsatisfactory positioning, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months other than a service to which item 32213 applies (Anaes.) **Fee:** $612.10 **Benefit:** 75% = $459.10
32217	Neurostimulator or receiver, removal of, if the neurostimulator or receiver was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and

	b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) **Fee:** $161.20 **Benefit:** 75% = $120.90
32218	Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) **Fee:** $161.20 **Benefit:** 75% = $120.90

	Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. Contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction or radiopaque solution; and (c) patients who enage in receptive anal intercourse (Anaes.) (Assist.)
32220	**Fee:** $932.15 **Benefit:** 75% = $699.15 85% = $847.45
	Removal or revision of an artificial bowel sphincter (with or without replacement) for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. Contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction to radiopaque solution; and (c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)
32221	**Fee:** $932.15 **Benefit:** 75% = $699.15 85% = $847.45
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) following a positive faecal occult blood test; or (b) who has symptoms consistent with pathology of the colonic mucosa; or (c) with anaemia or iron deficiency; or (d) for whom diagnostic imaging has shown an abnormality of the colon; or (e) who is undergoing the first examination following surgery for colorectal cancer; 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.) (See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category)
32222	**Fee:** $344.80 **Benefit:** 75% = $258.60 85% = $293.10
Amend 32223	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. (See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) **Fee:** $344.80 **Benefit:** 75% = $258.60 85% = $293.10
Amend 32224	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a moderate risk of colorectal cancer due to: (a) a history of adenomas, including an adenoma that: (i) was 10 mm or greater in diameter; or (ii) had villous features; or (iii) had high grade dysplasia; or (b) having had a previous colonoscopy that revealed: (i) 5 to 9 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or (ii) 1 or 2 sessile serrated lesions, each of which was 10 mm or greater in diameter or had dysplasia; or (iii) a hyperplastic polyp that was 10 mm or greater in diameter; or (iv) 3 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (v) 1 or 2 traditional serrated adenomas, of any size Applicable only once in any 3 year period (Anaes.) (See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) **Fee:** $344.80 **Benefit:** 75% = $258.60 85% = $293.10
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:** $344.80 **Benefit:** 75% = $258.60 85% = $293.10
Amend 32226	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk of colorectal cancer due to:

T8. SURGICAL OPERATIONS	2. COLORECTAL
	(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:** $344.80 **Benefit:** 75% = $258.60 85% = $293.10
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:** $483.85 **Benefit:** 75% = $362.90 85% = $411.30
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:** $344.80 **Benefit:** 75% = $258.60 85% = $293.10
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:** $278.10 **Benefit:** 75% = $208.60 85% = $236.40

T8. SURGICAL OPERATIONS	3. VASCULAR
	Group T8. Surgical Operations
	Subgroup 3. Vascular

	VARICOSE VEINS
32500	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding after-care) - to a maximum of 6 treatments in a 12 month period (Anaes.) (See para TN.8.4, TN.8.32 of explanatory notes to this Category) **Fee:** $113.20 **Benefit:** 75% = $84.90 85% = $96.25 **Extended Medicare Safety Net Cap:** $124.55
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:** $276.05 **Benefit:** 75% = $207.05 85% = $234.65 **Extended Medicare Safety Net Cap:** $220.85
32507	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $550.30 **Benefit:** 75% = $412.75 85% = $467.80 **Extended Medicare Safety Net Cap:** $440.25
32508	VARICOSE VEINS, complete dissection at the sapheno-femoral OR sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $550.30 **Benefit:** 75% = $412.75
32511	VARICOSE VEINS, complete dissection at the sapheno-femoral AND sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $818.10 **Benefit:** 75% = $613.60
32514	VARICOSE VEINS, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $955.75 **Benefit:** 75% = $716.85
32517	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $1,230.70 **Benefit:** 75% = $923.05
32520	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great or

	small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $550.30 **Benefit:** 75% = $412.75 85% = $467.80 **Extended Medicare Safety Net Cap:** $82.55
32522	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate embolisation, and not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $818.10 **Benefit:** 75% = $613.60 85% = $733.40 **Extended Medicare Safety Net Cap:** $81.85
32523	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including endovenous laser therapy or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $550.30 **Benefit:** 75% = $412.75 85% = $467.80 **Extended Medicare Safety Net Cap:** $82.55
32526	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including endovenous laser therapy or cyanoacrylate embolisation; and

	(c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $818.10 **Benefit:** 75% = $613.60 85% = $733.40 **Extended Medicare Safety Net Cap:** $81.85
32528	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $550.30 **Benefit:** 75% = $412.75 85% = $467.80 **Extended Medicare Safety Net Cap:** $82.55
32529	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $818.10 **Benefit:** 75% = $613.60 85% = $733.40 **Extended Medicare Safety Net Cap:** $81.85
	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,481.20 **Benefit:** 75% = $1110.90
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.) **Fee:** $1,225.30 **Benefit:** 75% = $919.00
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) **Fee:** $1,465.75 **Benefit:** 75% = $1099.35
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac

	arteries (Anaes.) (Assist.) **Fee:** $1,628.60 **Benefit:** 75% = $1221.45
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:** $1,791.55 **Benefit:** 75% = $1343.70
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,295.05 **Benefit:** 75% = $971.30
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) **Fee:** $1,295.05 **Benefit:** 75% = $971.30
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,225.30 **Benefit:** 75% = $919.00
32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) **Fee:** $1,946.30 **Benefit:** 75% = $1459.75
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) **Fee:** $2,210.05 **Benefit:** 75% = $1657.55
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,675.05 **Benefit:** 75% = $1256.30
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,946.30 **Benefit:** 75% = $1459.75
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) **Fee:** $426.45 **Benefit:** 75% = $319.85
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:** $1,333.80 **Benefit:** 75% = $1000.35
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:** $1,527.80 **Benefit:** 75% = $1145.85
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:** $1,744.80 **Benefit:** 75% = $1308.60
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:** $1,892.10 **Benefit:** 75% = $1419.10

	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.)
32751	**Fee:** $1,225.30 **Benefit:** 75% = $919.00
	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.)
32754	**Fee:** $1,527.80 **Benefit:** 75% = $1145.85
	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.)
32757	**Fee:** $426.45 **Benefit:** 75% = $319.85
	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.)
32760	**Fee:** $418.75 **Benefit:** 75% = $314.10
	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)
32763	**Fee:** $1,225.30 **Benefit:** 75% = $919.00
	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.)
32766	**Fee:** $814.35 **Benefit:** 75% = $610.80
	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.)
32769	**Fee:** $282.20 **Benefit:** 75% = $211.65
	BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS
	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.)
33050	**Fee:** $1,500.80 **Benefit:** 75% = $1125.60
	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.)
33055	**Fee:** $1,203.50 **Benefit:** 75% = $902.65
	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)
33070	**Fee:** $868.30 **Benefit:** 75% = $651.25 85% = $783.60
	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)
33075	**Fee:** $1,104.50 **Benefit:** 75% = $828.40
	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)
33080	**Fee:** $1,348.30 **Benefit:** 75% = $1011.25

	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.)
33100	**Fee:** $1,481.20 **Benefit:** 75% = $1110.90 85% = $1396.50
	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.)
33103	**Fee:** $2,078.25 **Benefit:** 75% = $1558.70
	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.)
33109	**Fee:** $2,512.65 **Benefit:** 75% = $1884.50 85% = $2427.95
	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.)
33112	**Fee:** $2,179.10 **Benefit:** 75% = $1634.35
	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.)
33115	**Fee:** $1,465.75 **Benefit:** 75% = $1099.35
	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.)
33116	**Fee:** $1,442.70 **Benefit:** 75% = $1082.05 85% = $1358.00
	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.)
33118	**Fee:** $1,628.60 **Benefit:** 75% = $1221.45
	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.)
33119	**Fee:** $1,603.10 **Benefit:** 75% = $1202.35 85% = $1518.40
	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.)
33121	**Fee:** $1,791.55 **Benefit:** 75% = $1343.70
	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.)
33124	**Fee:** $1,248.60 **Benefit:** 75% = $936.45
	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes.) (Assist.)
33127	**Fee:** $1,636.35 **Benefit:** 75% = $1227.30 85% = $1551.65
	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.)
33130	**Fee:** $1,426.90 **Benefit:** 75% = $1070.20
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of

	continuity (Anaes.) (Assist.) **Fee:** $1,070.05 **Benefit:** 75% = $802.55
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) **Fee:** $2,698.50 **Benefit:** 75% = $2023.90
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,636.35 **Benefit:** 75% = $1227.30
33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,527.80 **Benefit:** 75% = $1145.85 85% = $1443.10
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,628.85 **Benefit:** 75% = $1971.65
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,264.70 **Benefit:** 75% = $2448.55
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,101.90 **Benefit:** 75% = $2326.45
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) **Fee:** $2,295.40 **Benefit:** 75% = $1721.55
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:** $2,559.00 **Benefit:** 75% = $1919.25
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) **Fee:** $2,559.00 **Benefit:** 75% = $1919.25
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,171.50 **Benefit:** 75% = $1628.65
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.) **Fee:** $2,171.50 **Benefit:** 75% = $1628.65 85% = $2086.80
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) **Fee:** $1,690.60 **Benefit:** 75% = $1267.95
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,318.30 **Benefit:** 75% = $988.75

	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)
33175	**Fee:** $1,214.90 **Benefit:** 75% = $911.20
	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)
33178	**Fee:** $1,545.00 **Benefit:** 75% = $1158.75
	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)
33181	**Fee:** $1,888.90 **Benefit:** 75% = $1416.70
	ENDARTERECTOMY AND ARTERIAL PATCH
	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.)
33500	**Fee:** $1,170.85 **Benefit:** 75% = $878.15
	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.)
33506	**Fee:** $1,310.60 **Benefit:** 75% = $982.95
	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.)
33509	**Fee:** $1,465.75 **Benefit:** 75% = $1099.35
	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.)
33512	**Fee:** $1,628.60 **Benefit:** 75% = $1221.45
	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.)
33515	**Fee:** $1,791.55 **Benefit:** 75% = $1343.70
	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.)
33518	**Fee:** $1,310.60 **Benefit:** 75% = $982.95 85% = $1225.90
	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.)
33521	**Fee:** $1,419.05 **Benefit:** 75% = $1064.30
	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.)
33524	**Fee:** $1,675.05 **Benefit:** 75% = $1256.30
	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.)
33527	**Fee:** $1,946.30 **Benefit:** 75% = $1459.75
	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)
33530	**Fee:** $1,675.05 **Benefit:** 75% = $1256.30

	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)
33533	**Fee:** $1,946.30 **Benefit:** 75% = $1459.75
	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) (Assist.)
33536	**Fee:** $1,388.15 **Benefit:** 75% = $1041.15
	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.)
33539	**Fee:** $1,000.35 **Benefit:** 75% = $750.30
	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.)
33542	**Fee:** $1,426.90 **Benefit:** 75% = $1070.20
	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)
33545	**Fee:** $282.20 **Benefit:** 75% = $211.65
	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category)
33548	**Fee:** $574.00 **Benefit:** 75% = $430.50
	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)
33551	**Fee:** $282.20 **Benefit:** 75% = $211.65
	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.)
33554	**Fee:** $280.90 **Benefit:** 75% = $210.70
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA
	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.)
33800	**Fee:** $1,217.50 **Benefit:** 75% = $913.15 85% = $1132.80
	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.)
33803	**Fee:** $1,163.30 **Benefit:** 75% = $872.50
	Embolectomy or thrombectomy (including the infusion of thrombolytic or other agents) from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery, item to be claimed once per extremity, regardless of the number of incisions required to access the artery or bypass graft (Anaes.) (Assist.)
33806	**Fee:** $837.55 **Benefit:** 75% = $628.20 85% = $752.85
	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.)
33810	**Fee:** $611.00 **Benefit:** 75% = $458.25 85% = $526.30

	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.)
33811	**Fee:** $1,818.90 **Benefit:** 75% = $1364.20
	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.)
33812	**Fee:** $961.55 **Benefit:** 75% = $721.20 85% = $876.85
	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.)
33815	**Fee:** $884.05 **Benefit:** 75% = $663.05
	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.)
33818	**Fee:** $1,031.40 **Benefit:** 75% = $773.55
	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.)
33821	**Fee:** $1,178.70 **Benefit:** 75% = $884.05
	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.)
33824	**Fee:** $1,124.40 **Benefit:** 75% = $843.30
	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.)
33827	**Fee:** $1,318.30 **Benefit:** 75% = $988.75
	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.)
33830	**Fee:** $1,512.10 **Benefit:** 75% = $1134.10
	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.)
33833	**Fee:** $1,372.75 **Benefit:** 75% = $1029.60
	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.)
33836	**Fee:** $1,636.35 **Benefit:** 75% = $1227.30
	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.)
33839	**Fee:** $1,915.40 **Benefit:** 75% = $1436.55
	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.)
33842	**Fee:** $946.10 **Benefit:** 75% = $709.60
	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.)
33845	**Fee:** $659.20 **Benefit:** 75% = $494.40
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no

	other procedure is performed (Anaes.) (Assist.) **Fee:** $659.20 **Benefit:** 75% = $494.40
	LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS
34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.) **Fee:** $729.05 **Benefit:** 75% = $546.80
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:** $426.45 **Benefit:** 75% = $319.85
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:** $300.80 **Benefit:** 75% = $225.60 85% = $255.70 **Extended Medicare Safety Net Cap:** $240.65
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) **Fee:** $348.90 **Benefit:** 75% = $261.70 85% = $296.60
34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) **Fee:** $884.05 **Benefit:** 75% = $663.05
34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) **Fee:** $1,000.35 **Benefit:** 75% = $750.30
34118	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.) **Fee:** $1,426.90 **Benefit:** 75% = $1070.20 85% = $1342.20
34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,139.90 **Benefit:** 75% = $854.95
34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,248.60 **Benefit:** 75% = $936.45
34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,636.35 **Benefit:** 75% = $1227.30
34130	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.) **Fee:** $511.80 **Benefit:** 75% = $383.85 85% = $435.05
34133	SCALENOTOMY (Anaes.) (Assist.)

	Fee: $574.00 **Benefit:** 75% = $430.50
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.) **Fee:** $922.70 **Benefit:** 75% = $692.05
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:** $922.70 **Benefit:** 75% = $692.05
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.) **Fee:** $1,139.90 **Benefit:** 75% = $854.95
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) **Fee:** $829.75 **Benefit:** 75% = $622.35
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:** $1,481.20 **Benefit:** 75% = $1110.90
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:** $2,023.95 **Benefit:** 75% = $1518.00
34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.) **Fee:** $2,411.80 **Benefit:** 75% = $1808.85 85% = $2327.10
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) **Fee:** $1,225.30 **Benefit:** 75% = $919.00
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,295.40 **Benefit:** 75% = $1721.55
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,946.80 **Benefit:** 75% = $2210.10
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) **Fee:** $2,946.80 **Benefit:** 75% = $2210.10
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,636.35 **Benefit:** 75% = $1227.30
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,333.80 **Benefit:** 75% = $1000.35

	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.)
34175	**Fee:** $1,225.30 **Benefit:** 75% = $919.00
	OPERATIONS FOR VASCULAR ACCESS
	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.)
34500	**Fee:** $318.05 **Benefit:** 75% = $238.55 85% = $270.35
	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.)
34503	**Fee:** $426.45 **Benefit:** 75% = $319.85
	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.)
34506	**Fee:** $217.00 **Benefit:** 75% = $162.75
	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.)
34509	**Fee:** $1,008.10 **Benefit:** 75% = $756.10
	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.)
34512	**Fee:** $1,109.00 **Benefit:** 75% = $831.75
	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.)
34515	**Fee:** $790.95 **Benefit:** 75% = $593.25
	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.)
34518	**Fee:** $1,325.90 **Benefit:** 75% = $994.45
	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)
34521	**Fee:** $814.65 **Benefit:** 75% = $611.00
	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)
34524	**Fee:** $426.45 **Benefit:** 75% = $319.85
	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 catheterization, on a person 10 years of age or over (Anaes.)
34527	**Fee:** $568.85 **Benefit:** 75% = $426.65 85% = $484.15
	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a person 10 years of age or over (Anaes.)
34528	**Fee:** $280.90 **Benefit:** 75% = $210.70 85% = $238.80
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 catheterization, on a person under 10 years of age (Anaes.) **Fee:** $739.50 **Benefit:** 75% = $554.65 85% = $654.80
34530	CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital on a person 10 years of age or over (Anaes.) **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $179.05
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:** $1,279.40 **Benefit:** 75% = $959.55 85% = $1194.70
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 person under 10 years of age (Anaes.) **Fee:** $365.15 **Benefit:** 75% = $273.90 85% = $310.40
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:** $280.90 **Benefit:** 75% = $210.70 85% = $238.80
34539	TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical procedure (Anaes.) **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $179.05
34540	CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital, on a person under 10 years of age (Anaes.) **Fee:** $273.80 **Benefit:** 75% = $205.35 85% = $232.75
	COMPLEX VENOUS OPERATIONS
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) **Fee:** $837.55 **Benefit:** 75% = $628.20 85% = $752.85
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,845.80 **Benefit:** 75% = $1384.35
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) **Fee:** $1,000.35 **Benefit:** 75% = $750.30
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) **Fee:** $1,000.35 **Benefit:** 75% = $750.30
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:** $1,209.70 **Benefit:** 75% = $907.30
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: $1,000.35 **Benefit:** 75% = $750.30
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) **Fee:** $1,101.15 **Benefit:** 75% = $825.90
34821	VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.) **Fee:** $1,496.75 **Benefit:** 75% = $1122.60 85% = $1412.05
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.) **Fee:** $511.80 **Benefit:** 75% = $383.85
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.) **Fee:** $620.45 **Benefit:** 75% = $465.35
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.) **Fee:** $729.05 **Benefit:** 75% = $546.80 85% = $644.35
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) **Fee:** $946.10 **Benefit:** 75% = $709.60
	SYMPATHECTOMY
35000	LUMBAR SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $729.05 **Benefit:** 75% = $546.80 85% = $644.35
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) **Fee:** $946.10 **Benefit:** 75% = $709.60
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) **Fee:** $1,186.50 **Benefit:** 75% = $889.90
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) **Fee:** $922.70 **Benefit:** 75% = $692.05
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $729.05 **Benefit:** 75% = $546.80
	DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
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:** $380.05 **Benefit:** 75% = $285.05
35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.)

	Fee: $241.85 **Benefit:** 75% = $181.40
	MISCELLANEOUS VASCULAR PROCEDURES
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:** $176.85 **Benefit:** 75% = $132.65
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:** $842.60 **Benefit:** 75% = $631.95
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
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:** $531.45 **Benefit:** 75% = $398.60 85% = $451.75
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:** $681.40 **Benefit:** 75% = $511.05 85% = $596.70
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:** $628.95 **Benefit:** 75% = $471.75 85% = $544.25
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:** $1,156.20 **Benefit:** 75% = $867.15
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:** $786.15 **Benefit:** 75% = $589.65 85% = $701.45
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:** $891.00 **Benefit:** 75% = $668.25
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:** $891.00 **Benefit:** 75% = $668.25
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:** $366.90 **Benefit:** 75% = $275.20 85% = $311.90
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:** $657.70 **Benefit:** 75% = $493.30 85% = $573.00
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:** $883.45 **Benefit:** 75% = $662.60 85% = $798.75
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:** $838.70 **Benefit:** 75% = $629.05 85% = $754.00
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $314.50 **Benefit:** 75% = $235.90
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $421.50 **Benefit:** 75% = $316.15
35330	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $531.45 **Benefit:** 75% = $398.60 85% = $451.75
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:** $611.00 **Benefit:** 75% = $458.25
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:** $854.05 **Benefit:** 75% = $640.55
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:** $732.45 **Benefit:** 75% = $549.35
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:** $611.00 **Benefit:** 75% = $458.25
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:** $489.50 **Benefit:** 75% = $367.15
	INTERVENTIONAL RADIOLOGY PROCEDURES
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:** $357.45 **Benefit:** 75% = $268.10
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

T8. SURGICAL OPERATIONS	3. VASCULAR
	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:** $838.70 **Benefit:** 75% = $629.05
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:** $629.15 **Benefit:** 75% = $471.90
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.) (See para TN.8.34 of explanatory notes to this Category) **Fee:** $838.70 **Benefit:** 75% = $629.05 85% = $754.00
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 aftercare, including intra-operative imaging, but in association with the following pre-operative diagnostic imaging items: - either 60009 or 60010; and - either 60072, 60073, 60075, 60076, 60078 or 60079 (Anaes.) (Assist.) (See para TN.8.35 of explanatory notes to this Category) **Fee:** $2,946.80 **Benefit:** 75% = $2210.10 85% = $2862.10
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:** $3,609.35 **Benefit:** 75% = $2707.05

T8. SURGICAL OPERATIONS	4. GYNAECOLOGICAL
	Group T8. Surgical Operations

	Subgroup 4. Gynaecological
35500	GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $83.85 **Benefit:** 75% = $62.90 85% = $71.30
35502	INTRAUTERINE DEVICE, INTRODUCTION OF, for the control of idiopathic menorrhagia, AND ENDOMETRIAL BIOPSY to exclude endometrial pathology, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $82.65 **Benefit:** 75% = $62.00 85% = $70.30
35503	Intra uterine contraceptive device, introduction of, if the service is not associated with a service to which another item in this Group applies (other than a service mentioned in item 30062) (Anaes.) **Fee:** $55.20 **Benefit:** 75% = $41.40 85% = $46.95
35506	INTRAUTERINE CONTRACEPTIVE DEVICE, REMOVAL OF UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $55.35 **Benefit:** 75% = $41.55 85% = $47.05
35507	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) **Fee:** $179.90 **Benefit:** 75% = $134.95 85% = $152.95
35508	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) (Assist.) **Fee:** $264.95 **Benefit:** 75% = $198.75 85% = $225.25
35509	HYMENECTOMY (Anaes.) **Fee:** $92.25 **Benefit:** 75% = $69.20 85% = $78.45
35513	BARTHOLIN'S CYST, excision of (Anaes.) **Fee:** $228.65 **Benefit:** 75% = $171.50 85% = $194.40
35517	BARTHOLIN'S CYST OR GLAND, marsupialisation of (Anaes.) **Fee:** $150.60 **Benefit:** 75% = $112.95 85% = $128.05
35518	OVARIAN CYST ASPIRATION, for cysts of at least 4cm in diameter in a premenopausal person and at least 2cm in diameter in a postmenopausal person, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.) (See para TN.4.11 of explanatory notes to this Category) **Fee:** $214.35 **Benefit:** 75% = $160.80 85% = $182.20
35520	BARTHOLIN'S ABSCESS, incision of (Anaes.) **Fee:** $60.15 **Benefit:** 75% = $45.15 85% = $51.15

	URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes.)
35523	**Fee:** $60.15 **Benefit:** 75% = $45.15 85% = $51.15
	URETHRAL CARUNCLE, excision of (Anaes.)
35527	**Fee:** $150.60 **Benefit:** 75% = $112.95 85% = $128.05
	CLITORIS, amputation of, where medically indicated (Anaes.) (Assist.)
35530	**Fee:** $278.25 **Benefit:** 75% = $208.70
	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)
35533	**Fee:** $360.80 **Benefit:** 75% = $270.60
	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)
35534	**Fee:** $360.80 **Benefit:** 75% = $270.60
	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes.) (Assist.)
35536	**Fee:** $359.35 **Benefit:** 75% = $269.55 85% = $305.45
	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 1 anatomical site (Anaes.)
35539	**Fee:** $281.45 **Benefit:** 75% = $211.10 85% = $239.25
	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Anaes.) (Assist.)
35542	**Fee:** $329.55 **Benefit:** 75% = $247.20 85% = $280.15
	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for condylomata, unsuccessfully treated by other methods (Anaes.)
35545	**Fee:** $189.35 **Benefit:** 75% = $142.05 85% = $160.95
	VULVECTOMY, radical, for malignancy (Anaes.) (Assist.)
35548	**Fee:** $860.10 **Benefit:** 75% = $645.10
	Pelvic lymph nodes, radical excision of, unilateral, or sentinel node dissection (including any pre-operative injection) (Anaes.) (Assist.)
35551	**Fee:** $953.60 **Benefit:** 75% = $715.20

35552	Pelvic lymph nodes, radical excision of, unilateral, following similar previous dissection, radiation or chemotherapy (Anaes.) (Assist.) **Fee:** $1,434.60 **Benefit:** 75% = $1075.95
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.) **Fee:** $44.85 **Benefit:** 75% = $33.65 85% = $38.15
35557	VAGINA, removal of simple tumour (including Gartner duct cyst) (Anaes.) **Fee:** $221.20 **Benefit:** 75% = $165.90 85% = $188.05
35560	VAGINA, partial or complete removal of (Anaes.) (Assist.) **Fee:** $705.25 **Benefit:** 75% = $528.95
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,422.55 **Benefit:** 75% = $1066.95
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,167.95 **Benefit:** 75% = $876.00
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.) **Fee:** $539.15 **Benefit:** 75% = $404.40
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.) **Fee:** $705.25 **Benefit:** 75% = $528.95
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.) **Fee:** $409.65 **Benefit:** 75% = $307.25
35568	SACROSPINOUS COLPOPEXY FOR MANAGEMENT OF UPPER VAGINAL PROLAPSE (Anaes.) (Assist.) **Fee:** $644.10 **Benefit:** 75% = $483.10
35569	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes.) **Fee:** $165.85 **Benefit:** 75% = $124.40
Amend 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:** $571.15 **Benefit:** 75% = $428.40
Amend 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:** $571.15 **Benefit:** 75% = $428.40
35572	COLPOTOMY not being a service to which another item in this Group applies (Anaes.) **Fee:** $127.70 **Benefit:** 75% = $95.80
Amend 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:** $856.85 **Benefit:** 75% = $642.65
Amend 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:** $695.60 **Benefit:** 75% = $521.70
35578	LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $695.60 **Benefit:** 75% = $521.70
Amend 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:** $571.15 **Benefit:** 75% = $428.40
Amend 35582	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), $2cm^2$ or more in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35581 or 35585 applies (Anaes.) (Assist.)

	(See para TN.8.140 of explanatory notes to this Category) **Fee:** $856.85 **Benefit:** 75% = $642.65
Amend 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:** $1,519.20 **Benefit:** 75% = $1139.40
35595	LAPAROSCOPIC OR ABDOMINAL PELVIC FLOOR REPAIR INCORPORATING THE FIXATION OF THE UTEROSACRAL AND CARDINAL LIGAMENTS TO RECTOVAGINAL AND PUBOCERVICAL FASCIA for symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $1,191.10 **Benefit:** 75% = $893.35
35596	FISTULA BETWEEN GENITAL AND URINARY OR ALIMENTARY TRACTS, repair of, not being a service to which item 37029, 37333 or 37336 applies (Anaes.) (Assist.) **Fee:** $705.25 **Benefit:** 75% = $528.95
35597	SACRAL COLPOPEXY, laparoscopic or open procedure where graft or mesh secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $1,519.20 **Benefit:** 75% = $1139.40
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 30405 or 36812 applies (Anaes.) (Assist.) **Fee:** $781.55 **Benefit:** 75% = $586.20
35602	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; abdominal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $695.60 **Benefit:** 75% = $521.70
35605	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; vaginal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.) **Fee:** $377.40 **Benefit:** 75% = $283.05 85% = $320.80
35608	CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.) **Fee:** $65.95 **Benefit:** 75% = $49.50 85% = $56.10

35611	CERVIX, removal of polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.) **Fee:** $65.95 **Benefit:** 75% = $49.50 85% = $56.10
35612	CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes.) (Assist.) **Fee:** $521.80 **Benefit:** 75% = $391.35 85% = $443.55
35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.) **Fee:** $417.45 **Benefit:** 75% = $313.10
35614	EXAMINATION OF LOWER TRACT by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear screen result or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes.) (See para TN.8.42 of explanatory notes to this Category) **Fee:** $65.85 **Benefit:** 75% = $49.40 85% = $56.00
35615	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies **Fee:** $55.35 **Benefit:** 75% = $41.55 85% = $47.05
35616	ENDOMETRIUM, endoscopic examination of and ablation of, by microwave or thermal balloon or radiofrequency electrosurgery, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.) **Fee:** $463.65 **Benefit:** 75% = $347.75
35618	CERVIX, cone biopsy, amputation or repair of, other than a service to which item 35577 or 35578 applies (Anaes.) **Fee:** $224.80 **Benefit:** 75% = $168.60 85% = $191.10
35620	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.) **Fee:** $55.00 **Benefit:** 75% = $41.25 85% = $46.75
35622	ENDOMETRIUM, endoscopic ablation of, by laser or diathermy, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, not being a service associated with a service to which item 30390 applies (Anaes.) **Fee:** $621.30 **Benefit:** 75% = $466.00
35623	HYSTEROSCOPIC RESECTION of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.) **Fee:** $844.85 **Benefit:** 75% = $633.65
35626	HYSTEROSCOPY, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies (See para TN.8.43 of explanatory notes to this Category) **Fee:** $85.35 **Benefit:** 75% = $64.05 85% = $72.55
35627	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35630 applies (Anaes.)

	Fee: $110.50 **Benefit:** 75% = $82.90
35630	HYSTEROSCOPY, with endometrial biopsy, performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35627 applies (Anaes.) **Fee:** $188.75 **Benefit:** 75% = $141.60
35633	HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation (including for insertion of device for sterilisation) or removal of IUD which cannot be removed by other means, 1 or more of (Anaes.) **Fee:** $224.80 **Benefit:** 75% = $168.60 85% = $191.10
35634	HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.) **Fee:** $707.10 **Benefit:** 75% = $530.35 85% = $622.40
35635	HYSTEROSCOPY involving resection of the uterine septum (Anaes.) **Fee:** $308.80 **Benefit:** 75% = $231.60
35636	HYSTEROSCOPY, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.) **Fee:** $446.55 **Benefit:** 75% = $334.95
35637	LAPAROSCOPY, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (Anaes.) (Assist.) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $419.35 **Benefit:** 75% = $314.55
35638	COMPLICATED OPERATIVE LAPAROSCOPY, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, or division of utero-sacral ligaments for significant dysmenorrhoea - not being a service associated with any other intraperitoneal or retroperitoneal procedure except item 30393 (Anaes.) (Assist.) **Fee:** $733.75 **Benefit:** 75% = $550.35
35640	UTERUS, CURETTAGE OF, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block, including procedures to which item 35626, 35627 or 35630 applies, if performed (Anaes.) (See para TN.8.44 of explanatory notes to this Category) **Fee:** $188.75 **Benefit:** 75% = $141.60
35641	ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RESECTION OF, involving any two of the following procedures, resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter, resection of the Pouch of Douglas, resection of an ovarian endometrioma greater than 2 cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Anaes.) (Assist.) **Fee:** $1,281.50 **Benefit:** 75% = $961.15
35643	EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE other than a service to which item 35640 applies, including procedures to which item 35626, 35627 or 35630 applies, if performed (Anaes.)

	Fee: $224.80 **Benefit:** 75% = $168.60 85% = $191.10
35644	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, other than a service associated with a service to which item 35640 or 35647 applies (Anaes.) (See para TN.8.45 of explanatory notes to this Category) **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $178.50
35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes.) (See para TN.8.45 of explanatory notes to this Category) **Fee:** $328.65 **Benefit:** 75% = $246.50 85% = $279.40
35646	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix (Anaes.) (See para TN.8.45 of explanatory notes to this Category) **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $178.50
35647	CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes.) (See para TN.8.45 of explanatory notes to this Category) **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $178.50
35648	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes.) (See para TN.8.45 of explanatory notes to this Category) **Fee:** $328.65 **Benefit:** 75% = $246.50 85% = $279.40
35649	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.) **Fee:** $552.75 **Benefit:** 75% = $414.60
35653	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.) **Fee:** $695.80 **Benefit:** 75% = $521.85
35657	HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies NOTE: *Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim.* (Anaes.) (Assist.) (See para TN.8.46 of explanatory notes to this Category) **Fee:** $695.80 **Benefit:** 75% = $521.85
35658	UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal

	at hysterectomy (Anaes.) (Assist.) (See para TN.8.47 of explanatory notes to this Category) **Fee:** $429.05 **Benefit:** 75% = $321.80
35661	HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries (Anaes.) (Assist.) **Fee:** $898.55 **Benefit:** 75% = $673.95
35664	RADICAL HYSTERECTOMY with radical excision of pelvic lymph nodes (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.) **Fee:** $1,497.60 **Benefit:** 75% = $1123.20
35667	RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.) **Fee:** $1,272.80 **Benefit:** 75% = $954.60
35670	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph nodes, with or without removal of uterine adnexae (Anaes.) (Assist.) **Fee:** $1,048.05 **Benefit:** 75% = $786.05
35673	HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.) (Assist.) **Fee:** $781.45 **Benefit:** 75% = $586.10
35674	ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy (See para TN.4.11 of explanatory notes to this Category) **Fee:** $214.35 **Benefit:** 75% = $160.80 85% = $182.20
35677	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.) **Fee:** $552.75 **Benefit:** 75% = $414.60
35678	ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.) **Fee:** $666.45 **Benefit:** 75% = $499.85
35680	BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.) **Fee:** $600.20 **Benefit:** 75% = $450.15 85% = $515.50
35684	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes.) (Assist.) **Fee:** $485.90 **Benefit:** 75% = $364.45
35688	STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method 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.8.46 of explanatory notes to this Category) **Fee:** $409.65 **Benefit:** 75% = $307.25
	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)
35691	**Fee:** $163.65 **Benefit:** 75% = $122.75
	TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)
35694	**Fee:** $657.60 **Benefit:** 75% = $493.20
	MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)
35697	**Fee:** $975.75 **Benefit:** 75% = $731.85
	FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope (Anaes.) (Assist.)
35700	**Fee:** $752.90 **Benefit:** 75% = $564.70
	HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure not being a service associated with a service to which another item in this Sub-group applies (Anaes.)
35703	**Fee:** $69.65 **Benefit:** 75% = $52.25 85% = $59.25
	RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (Anaes.)
35706	**Fee:** $69.65 **Benefit:** 75% = $52.25 85% = $59.25
	FALLOPIAN TUBES, hydrotubation of, as a repetitive postoperative procedure (Anaes.)
35709	**Fee:** $44.85 **Benefit:** 75% = $33.65 85% = $38.15
	FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.) (Assist.)
35710	**Fee:** $477.75 **Benefit:** 75% = $358.35
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGO-OOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - one such procedure, other than a service associated with hysterectomy (Anaes.) (Assist.)
35713	**Fee:** $467.00 **Benefit:** 75% = $350.25
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGO-OOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 2 or more such procedures, unilateral or bilateral, other than a service associated with hysterectomy (Anaes.) (Assist.)
35717	**Fee:** $562.30 **Benefit:** 75% = $421.75

T8. SURGICAL OPERATIONS	4. GYNAECOLOGICAL
35720	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.) (See para TN.8.57 of explanatory notes to this Category) **Fee:** $695.60 **Benefit:** 75% = $521.70
35723	RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) **Fee:** $498.20 **Benefit:** 75% = $373.65
35726	INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) **Fee:** $498.20 **Benefit:** 75% = $373.65
35729	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.) **Fee:** $224.60 **Benefit:** 75% = $168.45
35730	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:** $224.60 **Benefit:** 75% = $168.45
35750	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $809.10 **Benefit:** 75% = $606.85
35753	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $894.70 **Benefit:** 75% = $671.05
35754	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Anaes.) (Assist.) **Fee:** $1,126.00 **Benefit:** 75% = $844.50
35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $809.10 **Benefit:** 75% = $606.85
35759	Procedure for the control of POST OPERATIVE HAEMORRHAGE following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Anaes.) (Assist.) **Fee:** $580.90 **Benefit:** 75% = $435.70

T8. SURGICAL OPERATIONS	5. UROLOGICAL
	Group T8. Surgical Operations

	Subgroup 5. Urological
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:** $714.05 **Benefit:** 75% = $535.55
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:** $289.65 **Benefit:** 75% = $217.25 85% = $246.25
	GENERAL
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $705.25 **Benefit:** 75% = $528.95
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) **Fee:** $1,434.60 **Benefit:** 75% = $1075.95
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) **Fee:** $807.45 **Benefit:** 75% = $605.60
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:** $953.60 **Benefit:** 75% = $715.20
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:** $1,331.45 **Benefit:** 75% = $998.60
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:** $1,142.60 **Benefit:** 75% = $856.95
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:** $1,623.65 **Benefit:** 75% = $1217.75
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:** $1,331.45 **Benefit:** 75% = $998.60
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:** $1,643.20 **Benefit:** 75% = $1232.40
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:** $1,194.05 **Benefit:** 75% = $895.55
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:** $1,713.80 **Benefit:** 75% = $1285.35
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:** $2,025.55 **Benefit:** 75% = $1519.20
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:** $713.00 **Benefit:** 75% = $534.75
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:** $1,331.45 **Benefit:** 75% = $998.60 85% = $1246.75
36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.) **Fee:** $713.00 **Benefit:** 75% = $534.75 85% = $628.30
36549	Ureterolithotomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.) **Fee:** $859.15 **Benefit:** 75% = $644.40
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) **Fee:** $764.65 **Benefit:** 75% = $573.50
36558	RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.) **Fee:** $670.10 **Benefit:** 75% = $502.60 85% = $585.40
36561	Renal biopsy, performed under image guidance (closed) (Anaes.) **Fee:** $177.90 **Benefit:** 75% = $133.45 85% = $151.25
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:** $953.60 **Benefit:** 75% = $715.20
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:** $1,048.05 **Benefit:** 75% = $786.05
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:** $1,331.45 **Benefit:** 75% = $998.60
36573	DIVIDED URETER, repair of (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
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:** $1,194.05 **Benefit:** 75% = $895.55
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:** $764.65 **Benefit:** 75% = $573.50
36585	URETER, transplantation of, into skin (Anaes.) (Assist.) **Fee:** $764.65 **Benefit:** 75% = $573.50
36588	URETER, reimplantation into bladder (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) **Fee:** $1,142.60 **Benefit:** 75% = $856.95
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.) (See para TN.8.153 of explanatory notes to this Category) **Fee:** $1,142.60 **Benefit:** 75% = $856.95 85% = $1057.90
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) (See para TN.8.153 of explanatory notes to this Category) **Fee:** $1,331.45 **Benefit:** 75% = $998.60
36604	Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional radiology techniques, but not including imaging (Anaes.) **Fee:** $276.05 **Benefit:** 75% = $207.05 85% = $234.65
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) **Fee:** $2,388.15 **Benefit:** 75% = $1791.15
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:** $712.30 **Benefit:** 75% = $534.25
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:** $276.05 **Benefit:** 75% = $207.05

36609	Intestinal urinary conduit, reservoir or ureterostomy, revision of (Anaes.) (Assist.) **Fee:** $764.65 **Benefit:** 75% = $573.50
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:** $1,830.50 **Benefit:** 75% = $1372.90
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:** $2,887.20 **Benefit:** 75% = $2165.40
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) **Fee:** $670.10 **Benefit:** 75% = $502.60
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:** $764.65 **Benefit:** 75% = $573.50
36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.) **Fee:** $670.10 **Benefit:** 75% = $502.60
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) **Fee:** $479.05 **Benefit:** 75% = $359.30
36624	Nephrostomy, percutaneous, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.) **Fee:** $575.55 **Benefit:** 75% = $431.70 85% = $490.85
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:** $713.00 **Benefit:** 75% = $534.75
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:** $764.65 **Benefit:** 75% = $573.50 85% = $679.95
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:** $412.40 **Benefit:** 75% = $309.30

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:** $859.15 **Benefit:** 75% = $644.40
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:** $1,099.60 **Benefit:** 75% = $824.70
36649	Nephrostomy drainage tube, exchange of, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.) **Fee:** $276.05 **Benefit:** 75% = $207.05 85% = $234.65
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:** $154.40 **Benefit:** 75% = $115.80
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:** $670.10 **Benefit:** 75% = $502.60
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:** $859.15 **Benefit:** 75% = $644.40
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:** $1,099.60 **Benefit:** 75% = $824.70
	OPERATIONS ON BLADDER
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:** $304.05 **Benefit:** 75% = $228.05 85% = $258.45
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:** $238.95 **Benefit:** 75% = $179.25 85% = $203.15
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:** $400.30 **Benefit:** 75% = $300.25 85% = $340.30
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:** $780.05 **Benefit:** 75% = $585.05 85% = $695.35
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:** $681.60 **Benefit:** 75% = $511.20 85% = $596.90
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: $612.10 **Benefit:** 75% = $459.10 85% = $527.40
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:** $129.30 **Benefit:** 75% = $97.00 85% = $109.95
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:** $344.45 **Benefit:** 75% = $258.35 85% = $292.80
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:** $161.20 **Benefit:** 75% = $120.90 85% = $137.05
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:** $161.20 **Benefit:** 75% = $120.90 85% = $137.05
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:** $206.25 **Benefit:** 75% = $154.70 85% = $175.35
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:** $206.25 **Benefit:** 75% = $154.70 85% = $175.35
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:** $206.25 **Benefit:** 75% = $154.70 85% = $175.35
36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes.) **Fee:** $28.45 **Benefit:** 75% = $21.35 85% = $24.20
36803	Ureteroscopy, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or

	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:** $480.90 **Benefit:** 75% = $360.70 85% = $408.80
36806	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:** $670.10 **Benefit:** 75% = $502.60
36809	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:** $859.15 **Benefit:** 75% = $644.40
36811	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:** $333.50 **Benefit:** 75% = $250.15 85% = $283.50
36812	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:** $171.90 **Benefit:** 75% = $128.95 85% = $146.15
36815	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:** $245.35 **Benefit:** 75% = $184.05 85% = $208.55
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:** $285.25 **Benefit:** 75% = $213.95 85% = $242.50
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:** $333.30 **Benefit:** 75% = $250.00 85% = $283.35
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:** $475.95 **Benefit:** 75% = $357.00 85% = $404.60
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:** $547.25 **Benefit:** 75% = $410.45 85% = $465.20
36824	Cystoscopy, with ureteric catheterisation, unilateral or bilateral, other than a service associated with a service to which item 36818 applies (Anaes.) **Fee:** $219.80 **Benefit:** 75% = $164.85 85% = $186.85
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:** $237.05 **Benefit:** 75% = $177.80 85% = $201.50
36830	CYSTOSCOPY, with ureteric meatotomy (Anaes.) **Fee:** $209.60 **Benefit:** 75% = $157.20
36833	Cystoscopy, with removal of ureteric stent or other foreign body in the lower urinary tract, unilateral (Anaes.) **Fee:** $285.25 **Benefit:** 75% = $213.95 85% = $242.50
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:** $237.05 **Benefit:** 75% = $177.80 85% = $201.50
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:** $333.30 **Benefit:** 75% = $250.00 85% = $283.35
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:** $335.35 **Benefit:** 75% = $251.55
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:** $713.00 **Benefit:** 75% = $534.75 85% = $628.30
36848	CYSTOSCOPY, with resection of ureterocele (Anaes.) **Fee:** $237.05 **Benefit:** 75% = $177.80
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:** $237.05 **Benefit:** 75% = $177.80
36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) **Fee:** $480.90 **Benefit:** 75% = $360.70
36860	ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (Anaes.) **Fee:** $171.90 **Benefit:** 75% = $128.95 85% = $146.15
36863	Litholapaxy, with or without cystoscopy (Anaes.) **Fee:** $480.90 **Benefit:** 75% = $360.70
37000	BLADDER, partial excision of (Anaes.) (Assist.) (See para TN.8.157 of explanatory notes to this Category) **Fee:** $764.65 **Benefit:** 75% = $573.50
37004	BLADDER, repair of rupture (Anaes.) (Assist.) **Fee:** $670.10 **Benefit:** 75% = $502.60
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:** $429.45 **Benefit:** 75% = $322.10 85% = $365.05
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:** $96.25 **Benefit:** 75% = $72.20 85% = $81.85
37014	BLADDER, total excision of (Anaes.) (Assist.) (See para TN.8.157 of explanatory notes to this Category) **Fee:** $1,099.60 **Benefit:** 75% = $824.70
37015	Bladder, total excision of, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis (Anaes.) (Assist.) **Fee:** $1,319.50 **Benefit:** 75% = $989.65
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:** $2,057.55 **Benefit:** 75% = $1543.20
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:** $3,086.35 **Benefit:** 75% = $2314.80
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:** $2,055.20 **Benefit:** 75% = $1541.40
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) **Fee:** $764.65 **Benefit:** 75% = $573.50
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:** $3,082.80 **Benefit:** 75% = $2312.10
37023	VESICAL FISTULA, cutaneous, operation for (Anaes.) **Fee:** $429.45 **Benefit:** 75% = $322.10
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) **Fee:** $429.45 **Benefit:** 75% = $322.10
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.)

	Fee: $713.35 **Benefit:** 75% = $535.05
37039	Bladder stress incontinence, sling procedure for, using a non-autologous biological sling (Anaes.) (Assist.) **Fee:** $695.60 **Benefit:** 75% = $521.70
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 30405 or 37042 applies (Anaes.) (Assist.) **Fee:** $939.80 **Benefit:** 75% = $704.85
37041	BLADDER ASPIRATION by needle **Fee:** $48.05 **Benefit:** 75% = $36.05 85% = $40.85
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 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $939.80 **Benefit:** 75% = $704.85
37043	Bladder stress incontinence, Stamey or similar type needle colposuspension, other than a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $695.60 **Benefit:** 75% = $521.70
37044	Bladder stress incontinence, suprapubic procedure for, eg Burch colposuspension, other than a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $713.35 **Benefit:** 75% = $535.05
37045	CONTINENT CATHETERISATION BLADDER STOMAS (eg. Mitrofanoff), formation of (Anaes.) (Assist.) **Fee:** $1,473.35 **Benefit:** 75% = $1105.05
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) **Fee:** $1,718.10 **Benefit:** 75% = $1288.60
37048	Bladder neck closure for the management of urinary incontinence (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) **Fee:** $764.65 **Benefit:** 75% = $573.50
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) **Fee:** $883.45 **Benefit:** 75% = $662.60
	OPERATIONS ON PROSTATE
37200	Prostatectomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.) (See para TN.8.162 of explanatory notes to this Category) **Fee:** $1,048.05 **Benefit:** 75% = $786.05
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:** $854.75 **Benefit:** 75% = $641.10
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:** $429.05 **Benefit:** 75% = $321.80 85% = $364.70
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:** $1,074.70 **Benefit:** 75% = $806.05
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:** $575.55 **Benefit:** 75% = $431.70
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:** $1,074.70 **Benefit:** 75% = $806.05
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:** $575.55 **Benefit:** 75% = $431.70
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:** $1,331.45 **Benefit:** 75% = $998.60
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:** $1,643.20 **Benefit:** 75% = $1232.40
37211	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.) (See para TN.8.161 of explanatory notes to this Category) **Fee:** $1,995.65 **Benefit:** 75% = $1496.75
37213	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.) (See para TN.8.161 of explanatory notes to this Category) **Fee:** $2,464.65 **Benefit:** 75% = $1848.50
37214	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.) (See para TN.8.161 of explanatory notes to this Category) **Fee:** $2,993.70 **Benefit:** 75% = $2245.30
37215	Prostate, biopsy of, endoscopic, with or without cystoscopy (Anaes.) **Fee:** $429.45 **Benefit:** 75% = $322.10 85% = $365.05
37216	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.) (See para TN.8.160 of explanatory notes to this Category) **Fee:** $144.85 **Benefit:** 75% = $108.65 85% = $123.15
37217	Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed, under ultrasound guidance, being an item associated with a service to which item 55603 applies (Anaes.)

	(See para TN.8.54 of explanatory notes to this Category) **Fee:** $142.60 **Benefit:** 75% = $106.95 85% = $121.25
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:** $142.60 **Benefit:** 75% = $106.95 85% = $121.25
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:** $347.60 **Benefit:** 75% = $260.70 85% = $295.50
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:** $1,076.80 **Benefit:** 75% = $807.60
37221	Prostatic abscess, endoscopic drainage of (Anaes.) **Fee:** $480.90 **Benefit:** 75% = $360.70
37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.) **Fee:** $212.70 **Benefit:** 75% = $159.55
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:** $333.30 **Benefit:** 75% = $250.00 85% = $283.35
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:** $583.50 **Benefit:** 75% = $437.65 85% = $498.80
37230	Prostate, ablation by electrocautery or high-energy transurethral microwave thermotherapy, with or without cystoscopy and with or without urethroscopy (Anaes.)

	(See para TN.8.163 of explanatory notes to this Category) **Fee:** $1,074.70 **Benefit:** 75% = $806.05 85% = $990.00
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:** $575.55 **Benefit:** 75% = $431.70 85% = $490.85
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:** $1,301.60 **Benefit:** 75% = $976.20
	OPERATIONS ON URETHRA, PENIS OR SCROTUM
37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.) **Fee:** $48.05 **Benefit:** 75% = $36.05 85% = $40.85
37303	URETHRAL STRICTURE, dilatation of (Anaes.) **Fee:** $76.40 **Benefit:** 75% = $57.30 85% = $64.95
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.) **Fee:** $670.10 **Benefit:** 75% = $502.60
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
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:** $285.25 **Benefit:** 75% = $213.95 85% = $242.50
37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes.) **Fee:** $96.25 **Benefit:** 75% = $72.20 85% = $81.85
37324	Urethrotomy or urethrostomy, internal or external (Anaes.) (Assist.) **Fee:** $237.05 **Benefit:** 75% = $177.80
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) **Fee:** $333.30 **Benefit:** 75% = $250.00
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) **Fee:** $670.10 **Benefit:** 75% = $502.60
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.)

	Fee: $575.55 **Benefit:** 75% = $431.70
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $764.65 **Benefit:** 75% = $573.50
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:** $939.80 **Benefit:** 75% = $704.85
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:** $247.35 **Benefit:** 75% = $185.55 85% = $210.25
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:** $939.80 **Benefit:** 75% = $704.85
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:** $939.80 **Benefit:** 75% = $704.85
37342	URETHROPLASTY single stage operation (Anaes.) (Assist.) **Fee:** $859.15 **Benefit:** 75% = $644.40
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:** $1,434.60 **Benefit:** 75% = $1075.95
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:** $939.80 **Benefit:** 75% = $704.85
37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.) **Fee:** $713.00 **Benefit:** 75% = $534.75
37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.) **Fee:** $713.00 **Benefit:** 75% = $534.75
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95
37354	HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.) **Fee:** $333.30 **Benefit:** 75% = $250.00

37369	URETHRA, excision of prolapse of (Anaes.) **Fee:** $192.45 **Benefit:** 75% = $144.35
37372	Urethral diverticulum, excision of (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) **Fee:** $1,194.05 **Benefit:** 75% = $895.55
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) **Fee:** $764.65 **Benefit:** 75% = $573.50
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) **Fee:** $1,194.05 **Benefit:** 75% = $895.55
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) **Fee:** $333.30 **Benefit:** 75% = $250.00
37388	Artificial urinary sphincter, sterile, percutaneous adjustment of filling volume **Fee:** $101.00 **Benefit:** 75% = $75.75 85% = $85.85
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
37393	PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.) **Fee:** $237.05 **Benefit:** 75% = $177.80 85% = $201.50
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) **Fee:** $764.65 **Benefit:** 75% = $573.50
37402	PENIS, partial amputation of (Anaes.) (Assist.) **Fee:** $480.90 **Benefit:** 75% = $360.70
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) **Fee:** $480.90 **Benefit:** 75% = $360.70
37411	PENIS, repair of avulsion (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20 85% = $868.90
37415	Penis, injection of, for the investigation and treatment of erectile dysfunction. Applicable not more than twice in a 36-month period

	Fee: $48.05 **Benefit:** 75% = $36.05 85% = $40.85
37417	Penis, correction of chordee by plication techniques including Nesbit's corporoplasty (Anaes.) (Assist.) **Fee:** $575.55 **Benefit:** 75% = $431.70
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:** $764.65 **Benefit:** 75% = $573.50 85% = $679.95
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:** $953.60 **Benefit:** 75% = $715.20
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) **Fee:** $1,005.00 **Benefit:** 75% = $753.75
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) **Fee:** $333.30 **Benefit:** 75% = $250.00
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) **Fee:** $953.60 **Benefit:** 75% = $715.20
37435	PENIS, frenuloplasty as an independent procedure (Anaes.) **Fee:** $96.25 **Benefit:** 75% = $72.20 85% = $81.85
37438	Scrotum, partial excision of, for histologically proven malignancy or infection (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95 85% = $242.50
	OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.) **Fee:** $285.25 **Benefit:** 75% = $213.95 85% = $242.50
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:** $285.25 **Benefit:** 75% = $213.95 85% = $242.50
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:** $385.15 **Benefit:** 75% = $288.90 85% = $327.40
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:** $571.85 **Benefit:** 75% = $428.90 85% = $487.15
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:** $1,430.40 **Benefit:** 75% = $1072.80
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:** $2,151.95 **Benefit:** 75% = $1614.00
37613	EPIDIDYMECTOMY (Anaes.) **Fee:** $285.25 **Benefit:** 75% = $213.95 85% = $242.50
37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $713.00 **Benefit:** 75% = $534.75
37619	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $285.25 **Benefit:** 75% = $213.95 85% = $242.50 **Extended Medicare Safety Net Cap:** $228.20
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:** $237.05 **Benefit:** 75% = $177.80 85% = $201.50
	PAEDIATRIC GENITURINARY SURGERY
37800	PATENT URACHUS, excision of, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $537.55 **Benefit:** 75% = $403.20
37801	PATENT URACHUS, excision of, when performed on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $698.85 **Benefit:** 75% = $524.15
37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $537.55 **Benefit:** 75% = $403.20
37804	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37807 applies, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $698.85 **Benefit:** 75% = $524.15
37806	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $621.10 **Benefit:** 75% = $465.85 85% = $536.40

	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a person under 10 years of age (Anaes.) (Assist.)
37807	**Fee:** $807.45 **Benefit:** 75% = $605.60 85% = $722.75
	UNDESCENDED TESTIS, revision orchidopexy for, on a person 10 years of age or over. (Anaes.) (Assist.)
37809	**Fee:** $621.10 **Benefit:** 75% = $465.85
	UNDESCENDED TESTIS, revision orchidopexy for, on a person under 10 years of age (Anaes.) (Assist.)
37810	**Fee:** $807.45 **Benefit:** 75% = $605.60
	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803, 37806 and 37809 applies, on a person 10 years of age or over. (Anaes.) (Assist.)
37812	**Fee:** $573.35 **Benefit:** 75% = $430.05
	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37804, 37807 and 37810 applies, on a person under 10 years of age (Anaes.) (Assist.)
37813	**Fee:** $745.35 **Benefit:** 75% = $559.05
	HYPOSPADIAS, examination under anaesthesia with erection test on a person 10 years of age or over. (Anaes.)
37815	**Fee:** $95.65 **Benefit:** 75% = $71.75
	HYPOSPADIAS, examination under anaesthesia with erection test, on a person under 10 years of age (Anaes.)
37816	**Fee:** $124.40 **Benefit:** 75% = $93.30
	HYPOSPADIAS, glanuloplasty incorporating meatal advancement, on a person 10 years of age or over (Anaes.) (Assist.)
37818	**Fee:** $506.80 **Benefit:** 75% = $380.10 85% = $430.80
	HYPOSPADIAS, glanuloplasty incorporating meatal advancement, on a person under 10 years of age (Anaes.) (Assist.)
37819	**Fee:** $658.85 **Benefit:** 75% = $494.15 85% = $574.15
	HYPOSPADIAS, distal, 1 stage repair, on a person 10 years of age or over. (Anaes.) (Assist.)
37821	**Fee:** $859.15 **Benefit:** 75% = $644.40
	HYPOSPADIAS, distal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.)
37822	**Fee:** $1,116.90 **Benefit:** 75% = $837.70
	HYPOSPADIAS, proximal, 1 stage repair on a person 10 years of age or over. (Anaes.) (Assist.)
37824	**Fee:** $1,194.50 **Benefit:** 75% = $895.90
	HYPOSPADIAS, proximal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.)
37825	**Fee:** $1,552.85 **Benefit:** 75% = $1164.65
	HYPOSPADIAS, staged repair, first stage, on a person 10 years of age or over. (Anaes.) (Assist.)
37827	**Fee:** $550.30 **Benefit:** 75% = $412.75

T8. SURGICAL OPERATIONS	5. UROLOGICAL
37828	HYPOSPADIAS, staged repair, first stage, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $715.35 **Benefit:** 75% = $536.55
37830	HYPOSPADIAS, staged repair, second stage, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $713.00 **Benefit:** 75% = $534.75 85% = $628.30
37831	HYPOSPADIAS, staged repair, second stage, on a person under 10 years of age. (Anaes.) (Assist.) **Fee:** $927.00 **Benefit:** 75% = $695.25 85% = $842.30
37833	Hypospadias, repair of urethral fistula, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $340.30 **Benefit:** 75% = $255.25
37834	Hypospadias, repair of urethral fistula, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $442.35 **Benefit:** 75% = $331.80
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) **Fee:** $716.70 **Benefit:** 75% = $537.55
37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) **Fee:** $812.20 **Benefit:** 75% = $609.15
37842	Exstrophy of bladder or epispadias, primary or secondary repair with or without bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) **Fee:** $1,576.85 **Benefit:** 75% = $1182.65
37845	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty, with or without endoscopy (Anaes.) (Assist.) **Fee:** $716.70 **Benefit:** 75% = $537.55
37848	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) **Fee:** $1,290.10 **Benefit:** 75% = $967.60
37851	Congenital disorder of sexual differentiation, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) **Fee:** $955.75 **Benefit:** 75% = $716.85
37854	Urethral valve, destruction of, including cystoscopy and urethroscopy (Anaes.) **Fee:** $377.90 **Benefit:** 75% = $283.45

T8. SURGICAL OPERATIONS	6. CARDIO-THORACIC
	Group T8. Surgical Operations
	Subgroup 6. Cardio-Thoracic
New 38426 S	Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) **Fee:** $467.50 **Benefit:** 75% = $350.65
	CARDIOLOGY PROCEDURES

38200	RIGHT HEART CATHETERISATION, with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $459.35 **Benefit:** 75% = $344.55 85% = $390.45
38203	LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $548.15 **Benefit:** 75% = $411.15 85% = $465.95
38206	RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $662.75 **Benefit:** 75% = $497.10 85% = $578.05
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:** $850.95 **Benefit:** 75% = $638.25 85% = $766.25
38212	CARDIAC ELECTROPHYSIOLOGICAL STUDY 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation not being a service associated with a service to which item 38209 or 38213 applies (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $1,415.30 **Benefit:** 75% = $1061.50 85% = $1330.60
38213	CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes.) **Fee:** $421.50 **Benefit:** 75% = $316.15 85% = $358.30
38215	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $366.00 **Benefit:** 75% = $274.50 85% = $311.10
38218	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $548.85 **Benefit:** 75% = $411.65 85% = $466.55
38220	SELECTIVE CORONARY GRAFT ANGIOGRAPHY placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)

	(See para TN.8.52 of explanatory notes to this Category) **Fee:** $182.95 **Benefit:** 75% = $137.25 85% = $155.55
38222	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $366.00 **Benefit:** 75% = $274.50 85% = $311.10
38225	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $548.95 **Benefit:** 75% = $411.75 85% = $466.65
38228	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $732.05 **Benefit:** 75% = $549.05 85% = $647.35
38231	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into the free coronary graft(s) attached to the aorta (irrespective of the number of grafts), and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $914.95 **Benefit:** 75% = $686.25 85% = $830.25
38234	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $731.90 **Benefit:** 75% = $548.95 85% = $647.20
38237	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $914.90 **Benefit:** 75% = $686.20 85% = $830.20
38240	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts)

	and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $1,097.85 **Benefit:** 75% = $823.40 85% = $1013.15
38241	USE OF A CORONARY PRESSURE WIRE during selective coronary angiography to measure fractional flow reserve (FFR) and coronary flow reserve (CFR) in one or more intermediate coronary artery or graft lesions (stenosis of 30-70%), to determine whether revascularisation should be performed where previous stress testing has either not been performed or the results are inconclusive (Anaes.) **Fee:** $484.35 **Benefit:** 75% = $363.30 85% = $411.70
38243	PLACEMENT OF CATHETER(S) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $457.45 **Benefit:** 75% = $343.10 85% = $388.85
38246	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $914.90 **Benefit:** 75% = $686.20 85% = $830.20
38256	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes.) **Fee:** $275.60 **Benefit:** 75% = $206.70 85% = $234.30
38270	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.) **Fee:** $940.80 **Benefit:** 75% = $705.60 85% = $856.10
38272	ATRIAL SEPTAL DEFECT closure, with septal occluder or other similar device, by transcatheter approach (Anaes.) (Assist.) **Fee:** $940.80 **Benefit:** 75% = $705.60 85% = $856.10
38273	Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (Anaes.) (Assist.) **Fee:** $940.80 **Benefit:** 75% = $705.60
38274	Ventricular septal defect, transcatheter closure of, with imaging and cardiac catheterisation (Anaes.) (Assist.) **Fee:** $940.80 **Benefit:** 75% = $705.60
38275	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.) **Fee:** $307.50 **Benefit:** 75% = $230.65 85% = $261.40
38276	Transcatheter occlusion of left atrial appendage, and cardiac catheterisation performed by the same practitioner, for stroke prevention in a patient who has non-valvular atrial fibrillation and a contraindication to life-long oral anticoagulation therapy, and is at increased risk of thromboembolism

	demonstrated by: (a) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non-central nervous system systemic embolism; or (b) at least 2 of the following risk factors: (i) an age of 65 years or more; (ii) hypertension; (iii) diabetes mellitus; (iv) heart failure or left ventricular ejection fraction of 35% or less (or both); (v) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque) (Anaes.) (Assist.) (See para TN.8.132 of explanatory notes to this Category) **Fee:** $940.80 **Benefit:** 75% = $705.60
38285	IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where: - a diagnosis has not been achieved through all other available cardiac investigations; and - a neurogenic cause is not suspected; and - it has been determined that the patient does not have structural heart disease associated with a high risk of sudden cardiac death. including initial programming and testing, as an admitted patient in an approved hospital (Anaes.) (See para TN.8.61 of explanatory notes to this Category) **Fee:** $198.95 **Benefit:** 75% = $149.25 85% = $169.15
38286	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital (Anaes.) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
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:** $198.95 **Benefit:** 75% = $149.25 85% = $169.15
	CATHETER BASED ARRHYTHMIA ABLATION
38287	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.) **Fee:** $2,164.05 **Benefit:** 75% = $1623.05 85% = $2079.35
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.) **Fee:** $2,755.40 **Benefit:** 75% = $2066.55
38293	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.) **Fee:** $2,957.65 **Benefit:** 75% = $2218.25 85% = $2872.95
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
38300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $531.45 **Benefit:** 75% = $398.60 85% = $451.75
38303	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (Anaes.) (Assist.) **Fee:** $681.40 **Benefit:** 75% = $511.05 85% = $596.70
38306	Transluminal insertion of stent or stents into one occlusional site, including associated balloon dilatation of coronary artery, percutaneous or by open exposure, excluding associated radiological services, radiological preparation and after-care (Anaes.) (Assist.) (See para TN.8.62 of explanatory notes to this Category) **Fee:** $786.15 **Benefit:** 75% = $589.65 85% = $701.45
38309	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary artery has been stented; and

	- each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) **Fee:** $913.10 **Benefit:** 75% = $684.85 85% = $828.40
38312	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) **Fee:** $1,167.70 **Benefit:** 75% = $875.80 85% = $1083.00
38315	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) **Fee:** $1,253.85 **Benefit:** 75% = $940.40 85% = $1169.15
38318	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) **Fee:** $1,635.95 **Benefit:** 75% = $1227.00 85% = $1551.25
	MISCELLANEOUS CARDIAC PROCEDURES
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:** $658.60 **Benefit:** 75% = $493.95
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:** $263.45 **Benefit:** 75% = $197.60
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:** $863.50 **Benefit:** 75% = $647.65
38358	Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Anaes.) (Assist.) (See para TN.8.64 of explanatory notes to this Category) **Fee:** $2,957.65 **Benefit:** 75% = $2218.25
38359	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.) **Fee:** $137.75 **Benefit:** 75% = $103.35 85% = $117.10
38362	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.) **Fee:** $396.95 **Benefit:** 75% = $297.75 85% = $337.45
38365	Permanent cardiac synchronisation device (including a cardiac synchronisation device that is capable of defibrillation), insertion, removal or replacement of, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) satisfied the requirements mentioned in paragraph (a) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) (See para TN.8.63 of explanatory notes to this Category) **Fee:** $263.45 **Benefit:** 75% = $197.60
38368	Permanent transvenous left ventricular electrode, insertion, removal or replacement of through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venogram of left ventricular veins, other than a service associated with a service to which item 35200 or 38200 applies, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and

	(ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms; or (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) (See para TN.8.63 of explanatory notes to this Category) **Fee:** $1,262.85 **Benefit:** 75% = $947.15
38371	Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association ((NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms (Anaes.) (See para TN.8.65 of explanatory notes to this Category) **Fee:** $296.85 **Benefit:** 75% = $222.65
38384	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after

	a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) **Fee:** $1,085.55 **Benefit:** 75% = $814.20 85% = $1000.85
38387	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies, not for defibrillators capable of cardiac resynchronisation therapy (Anaes.) (Assist.) **Fee:** $296.85 **Benefit:** 75% = $222.65 85% = $252.35
38390	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) **Fee:** $1,085.55 **Benefit:** 75% = $814.20 85% = $1000.85
38393	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies. (Anaes.) (Assist.) **Fee:** $296.85 **Benefit:** 75% = $222.65 85% = $252.35
	THORACIC SURGERY
38415	EMPYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.) **Fee:** $411.85 **Benefit:** 75% = $308.90 85% = $350.10
New 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:** $580.90 **Benefit:** 75% = $435.70 85% = $496.20
New 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:** $580.90 **Benefit:** 75% = $435.70 85% = $496.20
38418	THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Assist.) **Fee:** $988.35 **Benefit:** 75% = $741.30
New 38419 S	Bronchoscopy, as an independent procedure (Anaes.) **Fee:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10
New 38420 S	Bronchoscopy with one or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) **Fee:** $242.40 **Benefit:** 75% = $181.80 85% = $206.05
38421	THORACOTOMY, with pulmonary decortication (Anaes.) (Assist.) **Fee:** $1,579.85 **Benefit:** 75% = $1184.90
New 38422 S	Bronchus, removal of foreign body in (Anaes.) (Assist.) **Fee:** $379.25 **Benefit:** 75% = $284.45
New 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:** $264.95 **Benefit:** 75% = $198.75 85% = $225.25
38424	THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes.) (Assist.) **Fee:** $988.35 **Benefit:** 75% = $741.30
New 38425 S	Endoscopic laser resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $623.15 **Benefit:** 75% = $467.40
38427	THORACOPLASTY (complete) - 3 or more ribs (Anaes.) (Assist.) **Fee:** $1,220.40 **Benefit:** 75% = $915.30

38430	THORACOPLASTY (in stages) each stage (Anaes.) (Assist.) **Fee:** $628.95 **Benefit:** 75% = $471.75
38436	THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.) **Fee:** $257.55 **Benefit:** 75% = $193.20
38438	PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes.) (Assist.) **Fee:** $1,579.85 **Benefit:** 75% = $1184.90
38440	LUNG, wedge resection of (Anaes.) (Assist.) **Fee:** $1,183.05 **Benefit:** 75% = $887.30
38441	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.) **Fee:** $1,871.90 **Benefit:** 75% = $1403.95
38446	THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.) **Fee:** $1,220.40 **Benefit:** 75% = $915.30
38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,579.85 **Benefit:** 75% = $1184.90
38448	MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes.) (Assist.) **Fee:** $374.40 **Benefit:** 75% = $280.80
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $2,210.15 **Benefit:** 75% = $1657.65
38450	PERICARDIUM, transthoracic open surgical drainage of (Anaes.) (Assist.) **Fee:** $883.40 **Benefit:** 75% = $662.55
38452	PERICARDIUM, subxiphoid open surgical drainage of (Anaes.) (Assist.) **Fee:** $591.65 **Benefit:** 75% = $443.75
38453	TRACHEAL excision and repair without cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,774.70 **Benefit:** 75% = $1331.05
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $2,400.40 **Benefit:** 75% = $1800.30
38456	INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,579.85 **Benefit:** 75% = $1184.90

	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.)
38457	**Fee:** $1,474.95 **Benefit:** 75% = $1106.25
	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.)
38458	**Fee:** $786.15 **Benefit:** 75% = $589.65
	STERNAL WIRE OR WIRES, removal of (Anaes.)
38460	**Fee:** $284.00 **Benefit:** 75% = $213.00
	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes.)
38462	**Fee:** $336.60 **Benefit:** 75% = $252.45
	STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.)
38464	**Fee:** $365.90 **Benefit:** 75% = $274.45
	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.) (Assist.)
38466	**Fee:** $987.95 **Benefit:** 75% = $741.00
	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.)
38468	**Fee:** $1,522.25 **Benefit:** 75% = $1141.70
	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.)
38469	**Fee:** $1,774.70 **Benefit:** 75% = $1331.05
	CARDIAC SURGERY PROCEDURES
	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category)
38470	**Fee:** $988.35 **Benefit:** 75% = $741.30
	PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category)
38473	**Fee:** $591.65 **Benefit:** 75% = $443.75
	VALVULAR PROCEDURES
	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category)
38475	**Fee:** $857.75 **Benefit:** 75% = $643.35
	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category)
38477	**Fee:** $2,065.95 **Benefit:** 75% = $1549.50
38478	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481

	(Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,000.75 **Benefit:** 75% = $750.60
38480	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,065.95 **Benefit:** 75% = $1549.50
38481	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,351.90 **Benefit:** 75% = $1763.95
38483	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,774.70 **Benefit:** 75% = $1331.05
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:** $842.60 **Benefit:** 75% = $631.95
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,774.70 **Benefit:** 75% = $1331.05
38488	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,969.25 **Benefit:** 75% = $1476.95
38489	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,342.00 **Benefit:** 75% = $1756.50
38490	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $571.85 **Benefit:** 75% = $428.90
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:** $2,018.75 **Benefit:** 75% = $1514.10
38495	TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, in a TAVI Hospital on a TAVI Patient by a TAVI Practitioner – includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient. (Not payable more than once per patient in a five year period.) (Anaes.) (Assist.)

	(See para AN.33.1, TN.8.135 of explanatory notes to this Category) **Fee:** $1,476.95 **Benefit:** 75% = $1107.75 85% = $1392.25
	SURGERY FOR ISCHAEMIC HEART DISEASE
38496	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $643.45 **Benefit:** 75% = $482.60
38497	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service asociated with a service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,111.55 **Benefit:** 75% = $1583.70
38498	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,111.55 **Benefit:** 75% = $1583.70
38500	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,268.75 **Benefit:** 75% = $1701.60
38501	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38503, 38504 or 38600 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,268.75 **Benefit:** 75% = $1701.60
38503	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38500, 38501 or 38504 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,463.30 **Benefit:** 75% = $1847.50
38504	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38501, 38503 or 38600 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,463.30 **Benefit:** 75% = $1847.50
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts,

	each vessel (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $285.95 **Benefit:** 75% = $214.50
38506	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,677.05 **Benefit:** 75% = $1257.80
38507	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,968.85 **Benefit:** 75% = $1476.65
38508	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,463.30 **Benefit:** 75% = $1847.50
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,463.30 **Benefit:** 75% = $1847.50
	ARRHYTHMIA SURGERY
38512	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,164.05 **Benefit:** 75% = $1623.05
38515	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,755.40 **Benefit:** 75% = $2066.55
38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,957.65 **Benefit:** 75% = $2218.25
	PROCEDURES ON THORACIC AORTA
38550	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,213.20 **Benefit:** 75% = $1659.90
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,804.70 **Benefit:** 75% = $2103.55
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)

	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,201.70 **Benefit:** 75% = $2401.30
38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,610.05 **Benefit:** 75% = $1957.55
38562	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,201.70 **Benefit:** 75% = $2401.30
38565	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,591.00 **Benefit:** 75% = $2693.25
38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,921.15 **Benefit:** 75% = $1440.90
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,115.85 **Benefit:** 75% = $1586.90
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,049.15 **Benefit:** 75% = $1536.90
38577	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $571.85 **Benefit:** 75% = $428.90
	TECHNIQUES FOR PRESERVATION OF ARRESTED HEART
38588	CANNULATION of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $429.05 **Benefit:** 75% = $321.80
	CIRCULATORY SUPPORT PROCEDURES
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:** $1,579.85 **Benefit:** 75% = $1184.90
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management

	(Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $988.35 **Benefit:** 75% = $741.30
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $494.10 **Benefit:** 75% = $370.60
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $553.90 **Benefit:** 75% = $415.45 85% = $470.85
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $695.10 **Benefit:** 75% = $521.35
38615	Insertion of a left or right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,579.85 **Benefit:** 75% = $1184.90
38618	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; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,969.25 **Benefit:** 75% = $1476.95
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $786.15 **Benefit:** 75% = $589.65
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $883.40 **Benefit:** 75% = $662.55
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 (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $690.50 **Benefit:** 75% = $517.90
	RE-OPERATION
38637	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $571.85 **Benefit:** 75% = $428.90
38640	RE-OPERATION via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Anaes.) (Assist.) (See para TN.8.69, TN.8.67 of explanatory notes to this Category) **Fee:** $988.35 **Benefit:** 75% = $741.30
	MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES
38643	THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,100.75 **Benefit:** 75% = $825.60
38647	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
38650	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category)

	Fee: $1,969.25 **Benefit:** 75% = $1476.95
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,969.25 **Benefit:** 75% = $1476.95
38654	Permanent left ventricular electrode, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms; or (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) (Assist.) (See para TN.8.63, TN.8.67 of explanatory notes to this Category) **Fee:** $1,262.85 **Benefit:** 75% = $947.15
38656	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $988.35 **Benefit:** 75% = $741.30
	CARDIAC TUMOURS
38670	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,968.85 **Benefit:** 75% = $1476.65
38673	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,216.00 **Benefit:** 75% = $1662.00
38677	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.)

	(Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,073.15 **Benefit:** 75% = $1554.90
38680	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.) **Fee:** $2,459.05 **Benefit:** 75% = $1844.30 85% = $2374.35
	CONGENITAL CARDIAC SURGERY
38700	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,100.75 **Benefit:** 75% = $825.60
38703	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,984.20 **Benefit:** 75% = $1488.15
38706	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,879.30 **Benefit:** 75% = $1409.50
38709	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
38712	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,643.20 **Benefit:** 75% = $1982.40
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,759.60 **Benefit:** 75% = $1319.70
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
38721	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,542.55 **Benefit:** 75% = $1156.95
38724	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category)

	Fee: $2,201.20 **Benefit:** 75% = $1650.90
38727	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,542.55 **Benefit:** 75% = $1156.95
38730	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,542.55 **Benefit:** 75% = $1156.95
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,984.20 **Benefit:** 75% = $1488.15
38742	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,984.20 **Benefit:** 75% = $1488.15
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
38751	Ventricular septal defect, closure by direct suture or patch (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,755.40 **Benefit:** 75% = $2066.55
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category)

T8. SURGICAL OPERATIONS	6. CARDIO-THORACIC
	Fee: $2,201.20 **Benefit:** 75% = $1650.90
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,201.20 **Benefit:** 75% = $1650.90
	MISCELLANEOUS PROCEDURES ON THE CHEST
38800	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies **Fee:** $39.70 **Benefit:** 75% = $29.80 85% = $33.75
38803	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample **Fee:** $79.30 **Benefit:** 75% = $59.50 85% = $67.45
38806	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes.) **Fee:** $137.75 **Benefit:** 75% = $103.35 85% = $117.10
38809	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.) **Fee:** $169.70 **Benefit:** 75% = $127.30 85% = $144.25
38812	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.) **Fee:** $215.70 **Benefit:** 75% = $161.80 85% = $183.35
T8. SURGICAL OPERATIONS	**7. NEUROSURGICAL**
	Group T8. Surgical Operations
	Subgroup 7. Neurosurgical
	GENERAL
39000	LUMBAR PUNCTURE (Anaes.) **Fee:** $77.65 **Benefit:** 75% = $58.25 85% = $66.05
39007	Procedure to obtain access to intracranial space (including subdural space, ventricle or basal cistern), percutaneously or by burr-hole (Anaes.) **Fee:** $164.40 **Benefit:** 75% = $123.30 85% = $139.75
39013	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary

	posterior rami of spinal nerves (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $112.55 **Benefit:** 75% = $84.45 85% = $95.70
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:** $387.75 **Benefit:** 75% = $290.85
39018	Cerebrospinal reservoir, ventricular reservoir or external ventricular drain, insertion of, with or without stereotaxy (Anaes.) (Assist.) **Fee:** $852.50 **Benefit:** 75% = $639.40
	PAIN RELIEF
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $245.00 **Benefit:** 75% = $183.75 85% = $208.25
39109	Trigeminal gangliotomy by radiofrequency, balloon or glycerol, including stereotaxy (Anaes.) (Assist.) **Fee:** $1,461.90 **Benefit:** 75% = $1096.45 85% = $1377.20
39113	Cranial nerve, neurectomy or intracranial decompression of, using microsurgical techniques, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $2,452.40 **Benefit:** 75% = $1839.30
39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $77.65 **Benefit:** 75% = $58.25 85% = $66.05
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $307.15 **Benefit:** 75% = $230.40 85% = $261.10
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $651.50 **Benefit:** 75% = $488.65 85% = $566.80
39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) **Fee:** $1,667.30 **Benefit:** 75% = $1250.50
39125	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $307.35 **Benefit:** 75% = $230.55
39126	INFUSION PUMP, subcutaneous implantation or replacement of, and connection of the pump to an

	intrathecal or epidural catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $373.20 **Benefit:** 75% = $279.90
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of chronic intractable pain (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $488.45 **Benefit:** 75% = $366.35
39128	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion of, and connection of pump to catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $680.55 **Benefit:** 75% = $510.45
39130	EPIDURAL LEAD, percutaneous placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $695.20 **Benefit:** 75% = $521.40
39131	ELECTRODES, epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator by a medical practitioner, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris - each day **Fee:** $131.80 **Benefit:** 75% = $98.85 85% = $112.05
39133	Removal of subcutaneously IMPLANTED INFUSION PUMP OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of chronic intractable pain (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $164.40 **Benefit:** 75% = $123.30
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 intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.) **Fee:** $351.25 **Benefit:** 75% = $263.45
39135	NEUROSTIMULATOR or RECEIVER, that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.) **Fee:** $164.40 **Benefit:** 75% = $123.30
39136	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $164.40 **Benefit:** 75% = $123.30
39137	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, surgical repositioning to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, not being a service to which item 39130, 39138 or 39139 applies (Anaes.)

	Fee: $624.30 **Benefit:** 75% = $468.25
39138	PERIPHERAL NERVE LEAD, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) (Assist.) **Fee:** $695.20 **Benefit:** 75% = $521.40
39139	Epidural lead, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris—to a maximum of 4 leads (H) (Anaes.) (Assist.) **Fee:** $933.40 **Benefit:** 75% = $700.05
39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) **Fee:** $302.00 **Benefit:** 75% = $226.50 85% = $256.70
	PERIPHERAL NERVES
39300	CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $364.40 **Benefit:** 75% = $273.30
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $480.65 **Benefit:** 75% = $360.50
39306	NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $697.95 **Benefit:** 75% = $523.50
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $736.70 **Benefit:** 75% = $552.55
39312	NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $411.00 **Benefit:** 75% = $308.25
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,062.40 **Benefit:** 75% = $796.80
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $659.20 **Benefit:** 75% = $494.40
39321	NERVE, transposition of (Anaes.) (Assist.) **Fee:** $488.45 **Benefit:** 75% = $366.35
39323	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.) **Fee:** $285.45 **Benefit:** 75% = $214.10 85% = $242.65
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open

	operation (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $285.45 **Benefit:** 75% = $214.10 85% = $242.65
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 of explanatory notes to this Category) **Fee:** $488.55 **Benefit:** 75% = $366.45
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.) **Fee:** $285.45 **Benefit:** 75% = $214.10
39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes.) **Fee:** $285.45 **Benefit:** 75% = $214.10 85% = $242.65
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $411.00 **Benefit:** 75% = $308.25 85% = $349.35
	CRANIAL NERVES
39503	Facio-hypoglossal nerve or facio-accessory nerve, anastomosis of (Anaes.) (Assist.) (See para TN.8.166 of explanatory notes to this Category) **Fee:** $984.85 **Benefit:** 75% = $738.65
	CRANIO-CEREBRAL INJURIES
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:** $1,849.60 **Benefit:** 75% = $1387.20
39610	Fractured skull, without brain laceration or dural penetration, repair of (Anaes.) (Assist.) **Fee:** $984.85 **Benefit:** 75% = $738.65
39612	Fractured skull, with brain laceration or dural penetration but without cerebrospinal fluid, rhinorrhoea or otorrhoea, repair of (Anaes.) (Assist.) **Fee:** $1,155.50 **Benefit:** 75% = $866.65
39615	Fractured skull, after trauma, with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (Anaes.) (Assist.) **Fee:** $1,971.75 **Benefit:** 75% = $1478.85
	SKULL BASE SURGERY
39638	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—conjoint surgery, principal surgeon (Anaes.)

	(Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $4,390.15 **Benefit:** 75% = $3292.65
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:** $3,508.20 **Benefit:** 75% = $2631.15
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:** $4,630.50 **Benefit:** 75% = $3472.90
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:** $5,712.85 **Benefit:** 75% = $4284.65
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:** $4,390.15 **Benefit:** 75% = $3292.65
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:** $3,508.20 **Benefit:** 75% = $2631.15
	INTRA-CRANIAL NEOPLASMS
39700	Skull tumour, benign or malignant, excision of, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $1,869.00 **Benefit:** 75% = $1401.75
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:** $1,500.70 **Benefit:** 75% = $1125.55
39710	Intracranial tumour, one or more, biopsy, drainage, decompression or removal of, through a single craniotomy, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $2,499.10 **Benefit:** 75% = $1874.35
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:** $3,817.30 **Benefit:** 75% = $2863.00
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:** $2,786.00 **Benefit:** 75% = $2089.50
39718	Arachnoidal cyst, craniotomy for, including stereotaxy and neuroendoscopy (Anaes.) (Assist.) **Fee:** $1,682.90 **Benefit:** 75% = $1262.20
39720	Awake craniotomy for functional neurosurgery (Anaes.) (Assist.) **Fee:** $3,571.05 **Benefit:** 75% = $2678.30
	CEREBROVASCULAR DISEASE
39801	Aneurysm, clipping, proximal ligation, or reinforcement of sac, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $5,712.85 **Benefit:** 75% = $4284.65
39803	Intracranial arteriovenous malformation or fistula, treatment through a craniotomy, including stereotaxy, cranioplasty and all angiography (Anaes.) (Assist.) **Fee:** $5,712.85 **Benefit:** 75% = $4284.65
39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.) **Fee:** $1,884.35 **Benefit:** 75% = $1413.30 85% = $1799.65
39818	Intracranial vascular bypass using indirect techniques, including stereotaxy (Anaes.) (Assist.) **Fee:** $2,500.95 **Benefit:** 75% = $1875.75
39821	Intracranial vascular bypass using direct anastomosis techniques, including stereotaxy (Anaes.) (Assist.) **Fee:** $3,563.35 **Benefit:** 75% = $2672.55
40004	Ventricular, lumbar or cisternal shunt diversion, insertion or revision of, including stereotaxy (Anaes.) (Assist.) **Fee:** $1,706.15 **Benefit:** 75% = $1279.65
	INFECTION
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:** $1,500.70 **Benefit:** 75% = $1125.55
39903	Intracranial infection, treated by craniotomy, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) **Fee:** $2,252.90 **Benefit:** 75% = $1689.70
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: $822.00 **Benefit:** 75% = $616.50
	CEREBROSPINAL FLUID CIRCULATION DISORDERS
40012	Endoscopic ventriculostomy for treatment of cerebrospinal fluid circulation disorders, including stereotaxy (Anaes.) (Assist.) **Fee:** $1,764.30 **Benefit:** 75% = $1323.25
40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes.) **Fee:** $164.40 **Benefit:** 75% = $123.30 85% = $139.75
	CONGENITAL DISORDERS
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:** $1,046.95 **Benefit:** 75% = $785.25
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:** $2,485.45 **Benefit:** 75% = $1864.10
40109	Encephalocoele or cranial meningocele, excision and closure of, including stereotaxy and dermofat graft (Anaes.) (Assist.) **Fee:** $1,929.05 **Benefit:** 75% = $1446.80
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:** $2,464.15 **Benefit:** 75% = $1848.15
40119	Craniostenosis, operation for, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) **Fee:** $984.85 **Benefit:** 75% = $738.65
	SKULL RECONSTRUCTION
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 or 40703 applies (Anaes.) (Assist.) **Fee:** $984.85 **Benefit:** 75% = $738.65
	EPILEPSY
40700	Corpus callosotomy, for epilepsy, including stereotaxy (Anaes.) (Assist.) **Fee:** $2,415.70 **Benefit:** 75% = $1811.80
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:** $351.25 **Benefit:** 75% = $263.45

	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.)
40702	**Fee:** $164.40 **Benefit:** 75% = $123.30
	Corticectomy, topectomy or partial lobectomy, for epilepsy, including stereotaxy and cranioplasty (Anaes.) (Assist.)
40703	**Fee:** $2,499.10 **Benefit:** 75% = $1874.35
	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.)
40704	**Fee:** $695.20 **Benefit:** 75% = $521.40
	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of lead attached to left vagus nerve for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)
40705	**Fee:** $624.30 **Benefit:** 75% = $468.25
	Hemispherectomy or functional hemispherectomy, for intractable epilepsy, including stereotaxy (Anaes.) (Assist.)
40706	**Fee:** $3,571.10 **Benefit:** 75% = $2678.35
	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
40707	**Fee:** $195.65 **Benefit:** 75% = $146.75 85% = $166.35
	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.)
40708	**Fee:** $351.25 **Benefit:** 75% = $263.45
	Intracranial electrode placement by burr hole, including stereotaxy (Anaes.) (Assist.)
40709	**Fee:** $1,500.70 **Benefit:** 75% = $1125.55
40712	Intracranial electrode placement by craniotomy, single or multiple, including stereotactic EEG, including

	stereotaxy (Anaes.) (Assist.) **Fee:** $3,571.10 **Benefit:** 75% = $2678.35
	STEREOTACTIC PROCEDURES
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:** $1,800.35 **Benefit:** 75% = $1350.30
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:** $1,233.05 **Benefit:** 75% = $924.80 85% = $1148.35
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:** $2,335.20 **Benefit:** 75% = $1751.40
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:** $4,086.80 **Benefit:** 75% = $3065.10
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:** $351.25 **Benefit:** 75% = $263.45
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:** $542.80 **Benefit:** 75% = $407.10
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:** $263.45 **Benefit:** 75% = $197.60
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:** $542.80 **Benefit:** 75% = $407.10
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.) **Fee:** $2,085.90 **Benefit:** 75% = $1564.45
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:** $195.65 **Benefit:** 75% = $146.75 85% = $166.35

T8. SURGICAL OPERATIONS	7. NEUROSURGICAL
	MISCELLANEOUS
40905	Craniotomy, performed by a neurosurgeon in conjunction with the correction of craniofacial abnormalities (Anaes.) (Assist.) **Fee:** $620.50 **Benefit:** 75% = $465.40

T8. SURGICAL OPERATIONS	8. EAR, NOSE AND THROAT
	Group T8. Surgical Operations
	Subgroup 8. Ear, Nose And Throat
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:** $85.05 **Benefit:** 75% = $63.80 85% = $72.30
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:** $191.40 **Benefit:** 75% = $143.55 85% = $162.70
41503	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.) **Fee:** $246.25 **Benefit:** 75% = $184.70 85% = $209.35
41506	AURAL POLYP, removal of (Anaes.) **Fee:** $148.50 **Benefit:** 75% = $111.40 85% = $126.25
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.) **Fee:** $168.05 **Benefit:** 75% = $126.05 85% = $142.85
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:** $604.20 **Benefit:** 75% = $453.15
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:** $396.55 **Benefit:** 75% = $297.45

41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.) **Fee:** $957.75 **Benefit:** 75% = $718.35
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.) **Fee:** $1,019.70 **Benefit:** 75% = $764.80
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.) (Assist.) (See para TN.8.74 of explanatory notes to this Category) **Fee:** $294.60 **Benefit:** 75% = $220.95
41527	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.) **Fee:** $605.95 **Benefit:** 75% = $454.50
41530	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.) **Fee:** $987.20 **Benefit:** 75% = $740.40
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,180.05 **Benefit:** 75% = $885.05
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,321.75 **Benefit:** 75% = $991.35
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) **Fee:** $1,123.95 **Benefit:** 75% = $843.00
41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.) **Fee:** $1,231.55 **Benefit:** 75% = $923.70
41545	MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.) **Fee:** $537.55 **Benefit:** 75% = $403.20
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) **Fee:** $713.35 **Benefit:** 75% = $535.05
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.) **Fee:** $1,642.85 **Benefit:** 75% = $1232.15
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.) **Fee:** $1,935.60 **Benefit:** 75% = $1451.70
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.) **Fee:** $1,123.95 **Benefit:** 75% = $843.00
41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.) **Fee:** $1,231.55 **Benefit:** 75% = $923.70

41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) **Fee:** $1,524.60 **Benefit:** 75% = $1143.45
41564	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTOID CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes.) (Assist.) **Fee:** $1,971.55 **Benefit:** 75% = $1478.70
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.) **Fee:** $1,123.95 **Benefit:** 75% = $843.00
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.) **Fee:** $1,231.55 **Benefit:** 75% = $923.70
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) **Fee:** $1,065.50 **Benefit:** 75% = $799.15
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:** $2,511.75 **Benefit:** 75% = $1883.85
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:** $3,767.75 **Benefit:** 75% = $2825.85
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,511.75 **Benefit:** 75% = $1883.85
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,883.85 **Benefit:** 75% = $1412.90
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) **Fee:** $2,889.05 **Benefit:** 75% = $2166.80
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) **Fee:** $1,982.70 **Benefit:** 75% = $1487.05
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) **Fee:** $2,700.40 **Benefit:** 75% = $2025.30
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.)

	Fee: $1,231.55 **Benefit:** 75% = $923.70
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) **Fee:** $1,605.10 **Benefit:** 75% = $1203.85
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) **Fee:** $1,793.85 **Benefit:** 75% = $1345.40
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) **Fee:** $1,793.85 **Benefit:** 75% = $1345.40
41603	OSSEO-INTEGRATION PROCEDURE - implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) **Fee:** $519.60 **Benefit:** 75% = $389.70 85% = $441.70
41604	OSSEO-INTEGRATION PROCEDURE - fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) **Fee:** $192.35 **Benefit:** 75% = $144.30 85% = $163.50
41608	STAPEDECTOMY (Anaes.) (Assist.) **Fee:** $1,123.95 **Benefit:** 75% = $843.00
41611	STAPES MOBILISATION (Anaes.) (Assist.) **Fee:** $723.20 **Benefit:** 75% = $542.40
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.) **Fee:** $1,123.95 **Benefit:** 75% = $843.00 85% = $1039.25
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:** $1,123.95 **Benefit:** 75% = $843.00 85% = $1039.25

41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,954.40 **Benefit:** 75% = $1465.80
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:** $1,935.60 **Benefit:** 75% = $1451.70
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) **Fee:** $850.30 **Benefit:** 75% = $637.75
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,231.55 **Benefit:** 75% = $923.70
41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $148.50 **Benefit:** 75% = $111.40 85% = $126.25
41629	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.) **Fee:** $537.55 **Benefit:** 75% = $403.20
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.) **Fee:** $246.25 **Benefit:** 75% = $184.70 85% = $209.35
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,180.05 **Benefit:** 75% = $885.05 85% = $1095.35
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.) **Fee:** $1,472.95 **Benefit:** 75% = $1104.75

41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.) **Fee:** $48.90 **Benefit:** 75% = $36.70 85% = $41.60
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) **Fee:** $147.30 **Benefit:** 75% = $110.50 85% = $125.25
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.) **Fee:** $113.30 **Benefit:** 75% = $85.00 85% = $96.35
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:** $113.30 **Benefit:** 75% = $85.00 85% = $96.35
41653	EXAMINATION OF NASAL CAVITY or POSTNASAL SPACE, or NASAL CAVITY AND POSTNASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $74.20 **Benefit:** 75% = $55.65 85% = $63.10
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:** $126.65 **Benefit:** 75% = $95.00 85% = $107.70
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.) **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of (See para TN.8.75 of explanatory notes to this Category) **Fee:** $85.05 **Benefit:** 75% = $63.80 85% = $72.30
41668	NASAL POLYP OR POLYPI, removal of (Anaes.) (See para TN.8.75 of explanatory notes to this Category) **Fee:** $226.80 **Benefit:** 75% = $170.10
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $498.35 **Benefit:** 75% = $373.80
41672	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) **Fee:** $621.70 **Benefit:** 75% = $466.30
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:** $103.65 **Benefit:** 75% = $77.75 85% = $88.15
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity

	packing or both (Anaes.) **Fee:** $92.80 **Benefit:** 75% = $69.60 85% = $78.90
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:** $120.90 **Benefit:** 75% = $90.70 85% = $102.80
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:** $74.20 **Benefit:** 75% = $55.65 85% = $63.10
41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.) **Fee:** $140.80 **Benefit:** 75% = $105.60
41692	TURBINATES, submucous resection of, unilateral (Anaes.) **Fee:** $183.60 **Benefit:** 75% = $137.70
41698	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) **Fee:** $33.55 **Benefit:** 75% = $25.20 85% = $28.55
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:** $94.75 **Benefit:** 75% = $71.10
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $37.45 **Benefit:** 75% = $28.10 85% = $31.85
41707	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.) **Fee:** $462.60 **Benefit:** 75% = $346.95
41710	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) **Fee:** $537.55 **Benefit:** 75% = $403.20
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.) **Fee:** $625.45 **Benefit:** 75% = $469.10
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) **Fee:** $304.95 **Benefit:** 75% = $228.75
41719	ANTRUM, drainage of, through tooth socket (Anaes.) **Fee:** $121.25 **Benefit:** 75% = $90.95 85% = $103.10
41722	OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) **Fee:** $605.95 **Benefit:** 75% = $454.50 85% = $521.25

41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.) **Fee:** $462.60 **Benefit:** 75% = $346.95
41728	LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.) **Fee:** $925.30 **Benefit:** 75% = $694.00
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.) **Fee:** $801.40 **Benefit:** 75% = $601.05
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.) **Fee:** $1,045.70 **Benefit:** 75% = $784.30
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.) **Fee:** $498.35 **Benefit:** 75% = $373.80
41740	FRONTAL SINUS, catheterisation of (Anaes.) **Fee:** $60.65 **Benefit:** 75% = $45.50
41743	FRONTAL SINUS, trephine of (Anaes.) (Assist.) **Fee:** $348.00 **Benefit:** 75% = $261.00
41746	FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.) **Fee:** $801.40 **Benefit:** 75% = $601.05 85% = $716.70
41749	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.) **Fee:** $625.45 **Benefit:** 75% = $469.10
41752	SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.) **Fee:** $304.95 **Benefit:** 75% = $228.75
41755	EUSTACHIAN TUBE, catheterisation of (Anaes.) **Fee:** $47.95 **Benefit:** 75% = $36.00 85% = $40.80
41764	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures, unilateral or bilateral examination (Anaes.) **Fee:** $126.65 **Benefit:** 75% = $95.00 85% = $107.70
41767	NASOPHARYNGEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.) **Fee:** $760.05 **Benefit:** 75% = $570.05 85% = $675.35
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.) **Fee:** $723.20 **Benefit:** 75% = $542.40
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.)

	Fee: $605.95 **Benefit:** 75% = $454.50
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.) **Fee:** $604.20 **Benefit:** 75% = $453.15
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) **Fee:** $723.20 **Benefit:** 75% = $542.40
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.) **Fee:** $981.85 **Benefit:** 75% = $736.40 85% = $897.15
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.) **Fee:** $1,218.05 **Benefit:** 75% = $913.55
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) **Fee:** $760.05 **Benefit:** 75% = $570.05
41787	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $501.70
41789	Tonsils or tonsils and adenoids, removal of, in a person 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:** $304.95 **Benefit:** 75% = $228.75
41793	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.) **Fee:** $383.10 **Benefit:** 75% = $287.35
41797	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) **Fee:** $148.50 **Benefit:** 75% = $111.40
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:** $168.05 **Benefit:** 75% = $126.05
41804	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.) **Fee:** $92.80 **Benefit:** 75% = $69.60
41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.) **Fee:** $72.25 **Benefit:** 75% = $54.20 85% = $61.45

41810	UVULOTOMY or UVULECTOMY (Anaes.) **Fee:** $36.70 **Benefit:** 75% = $27.55 85% = $31.20
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65
41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes.) **Fee:** $191.40 **Benefit:** 75% = $143.55 85% = $162.70
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes.) **Fee:** $246.25 **Benefit:** 75% = $184.70
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.) **Fee:** $53.85 **Benefit:** 75% = $40.40 85% = $45.80
41831	Oesophagus, endoscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.) **Fee:** $368.15 **Benefit:** 75% = $276.15 85% = $312.95
41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.) **Fee:** $235.65 **Benefit:** 75% = $176.75 85% = $200.35
41834	LARYNGECTOMY (TOTAL) (Anaes.) (Assist.) **Fee:** $1,329.45 **Benefit:** 75% = $997.10
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.) **Fee:** $1,274.70 **Benefit:** 75% = $956.05
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.) **Fee:** $1,567.25 **Benefit:** 75% = $1175.45
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) **Fee:** $1,378.20 **Benefit:** 75% = $1033.65
41855	MICROLARYNGOSCOPY (Anaes.) (Assist.) **Fee:** $297.20 **Benefit:** 75% = $222.90
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.) (See para TN.8.77 of explanatory notes to this Category) **Fee:** $509.60 **Benefit:** 75% = $382.20
41861	MICROLARYNGOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.) (Assist.) **Fee:** $623.15 **Benefit:** 75% = $467.40
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.)

	Fee: $420.20 **Benefit:** 75% = $315.15
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.) **Fee:** $632.55 **Benefit:** 75% = $474.45
41868	LARYNGEAL WEB, division of, using microlarygoscopic techniques (Anaes.) **Fee:** $400.80 **Benefit:** 75% = $300.60
41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.) **Fee:** $469.10 **Benefit:** 75% = $351.85
41873	LARYNX, FRACTURED, operation for (Anaes.) (Assist.) **Fee:** $605.95 **Benefit:** 75% = $454.50 85% = $521.25
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.) **Fee:** $605.95 **Benefit:** 75% = $454.50 85% = $521.25
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.) **Fee:** $981.85 **Benefit:** 75% = $736.40
41880	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.) **Fee:** $262.05 **Benefit:** 75% = $196.55
41881	TRACHEOSTOMY by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes.) (Assist.) **Fee:** $414.30 **Benefit:** 75% = $310.75
41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using mini tracheostomy device (Anaes.) **Fee:** $93.90 **Benefit:** 75% = $70.45
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $296.90 **Benefit:** 75% = $222.70 85% = $252.40
41886	TRACHEA, removal of foreign body in (Anaes.) **Fee:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10
41904	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.) **Fee:** $254.20 **Benefit:** 75% = $190.65 85% = $216.10
41907	NASAL SEPTUM BUTTON, insertion of (Anaes.) **Fee:** $126.65 **Benefit:** 75% = $95.00 85% = $107.70
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $402.45 **Benefit:** 75% = $301.85

	Group T8. Surgical Operations
	Subgroup 9. Ophthalmology
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $105.70 **Benefit:** 75% = $79.30
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:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65 **Extended Medicare Safety Net Cap:** $46.55
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:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65 **Extended Medicare Safety Net Cap:** $46.55
42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.) **Fee:** $496.30 **Benefit:** 75% = $372.25 85% = $421.90
42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.) **Fee:** $628.10 **Benefit:** 75% = $471.10
42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.) **Fee:** $724.00 **Benefit:** 75% = $543.00
42512	GLOBE, EVISCERATION OF (Anaes.) (Assist.) **Fee:** $496.30 **Benefit:** 75% = $372.25 85% = $421.90
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.) **Fee:** $628.10 **Benefit:** 75% = $471.10
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:** $364.40 **Benefit:** 75% = $273.30
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) **Fee:** $1,240.80 **Benefit:** 75% = $930.60
42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.) **Fee:** $210.95 **Benefit:** 75% = $158.25 85% = $179.35
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) **Fee:** $418.75 **Benefit:** 75% = $314.10
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.) **Fee:** $651.50 **Benefit:** 75% = $488.65
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.) **Fee:** $418.75 **Benefit:** 75% = $314.10
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.) **Fee:** $860.65 **Benefit:** 75% = $645.50
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.) **Fee:** $1,225.30 **Benefit:** 75% = $919.00
42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $519.60 **Benefit:** 75% = $389.70
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $911.45 **Benefit:** 75% = $683.60
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:** $1,318.30 **Benefit:** 75% = $988.75
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) **Fee:** $783.10 **Benefit:** 75% = $587.35
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:** $651.50 **Benefit:** 75% = $488.65 85% = $566.80
42554	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.)

	Fee: $760.05 **Benefit:** 75% = $570.05
42557	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) **Fee:** $1,062.40 **Benefit:** 75% = $796.80
42563	INTRAOCULAR FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.) **Fee:** $535.20 **Benefit:** 75% = $401.40 85% = $454.95
42569	INTRAOCULAR FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.) **Fee:** $1,062.40 **Benefit:** 75% = $796.80
42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes.) **Fee:** $121.05 **Benefit:** 75% = $90.80 85% = $102.90
42573	DERMOID, periorbital, excision of, on a person 10 years of age or over (Anaes.) **Fee:** $234.55 **Benefit:** 75% = $175.95 85% = $199.40
42574	DERMOID, orbital, excision of (Anaes.) (Assist.) **Fee:** $498.35 **Benefit:** 75% = $373.80 85% = $423.60
42575	TARSAL CYST, extirpation of (Anaes.) **Fee:** $85.30 **Benefit:** 75% = $64.00 85% = $72.55
42576	DERMOID, periorbital, excision of, on a person under 10 years of age (Anaes.) **Fee:** $304.95 **Benefit:** 75% = $228.75 85% = $259.25
42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.) **Fee:** $121.05 **Benefit:** 75% = $90.80 85% = $102.90
42584	TARSORRHAPHY (Anaes.) (Assist.) **Fee:** $285.45 **Benefit:** 75% = $214.10 85% = $242.65
42587	TRICHIASIS (due to causes other than trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $53.60 **Benefit:** 75% = $40.20 85% = $45.60
42588	TRICHIASIS (due to trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $53.60 **Benefit:** 75% = $40.20 85% = $45.60
42590	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.) **Fee:** $348.90 **Benefit:** 75% = $261.70 85% = $296.60 **Extended Medicare Safety Net Cap:** $279.15
42593	LACRIMAL GLAND, excision of palpebral lobe (Anaes.) **Fee:** $210.95 **Benefit:** 75% = $158.25
42596	LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.) **Fee:** $519.60 **Benefit:** 75% = $389.70 85% = $441.70
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone

	tubes or similar, 1 eye (Anaes.) (Assist.) **Fee:** $651.50 **Benefit:** 75% = $488.65 85% = $566.80
42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.) **Fee:** $651.50 **Benefit:** 75% = $488.65 85% = $566.80
42605	LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.) **Fee:** $480.65 **Benefit:** 75% = $360.50 85% = $408.60
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) **Fee:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65
42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $99.25 **Benefit:** 75% = $74.45 85% = $84.40
42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $148.85 **Benefit:** 75% = $111.65 85% = $126.55
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:** $49.80 **Benefit:** 75% = $37.35 85% = $42.35
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:** $74.50 **Benefit:** 75% = $55.90 85% = $63.35
42617	PUNCTUM SNIP operation (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10
42620	PUNCTUM, occlusion of, by use of a plug (Anaes.) **Fee:** $54.30 **Benefit:** 75% = $40.75 85% = $46.20
42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.) **Fee:** $85.30 **Benefit:** 75% = $64.00 85% = $72.55
42623	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.) **Fee:** $721.30 **Benefit:** 75% = $541.00
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.) **Fee:** $1,163.30 **Benefit:** 75% = $872.50 85% = $1078.60
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.)

	Fee: $876.25 **Benefit:** 75% = $657.20
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.) **Fee:** $121.05 **Benefit:** 75% = $90.80 85% = $102.90
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) **Fee:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) **Fee:** $387.75 **Benefit:** 75% = $290.85 85% = $329.60
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.) **Fee:** $504.00 **Benefit:** 75% = $378.00 85% = $428.40
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:** $74.40 **Benefit:** 75% = $55.80 85% = $63.25
42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.) **Fee:** $210.95 **Benefit:** 75% = $158.25 85% = $179.35
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:** $74.40 **Benefit:** 75% = $55.80 85% = $63.25
42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.) **Fee:** $165.80 **Benefit:** 75% = $124.35 85% = $140.95
42652	Corneal collagen cross linking, on a person with a corneal ectatic disorder, with evidence of progression—per eye. (Anaes.) (See para TN.8.136 of explanatory notes to this Category) **Fee:** $1,237.50 **Benefit:** 75% = $928.15 85% = $1152.80
42653	CORNEA transplantation of (Anaes.) (Assist.) **Fee:** $1,348.60 **Benefit:** 75% = $1011.45
42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.) **Fee:** $1,721.60 **Benefit:** 75% = $1291.20
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) **Fee:** $930.50 **Benefit:** 75% = $697.90
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.) **Fee:** $620.45 **Benefit:** 75% = $465.35 85% = $535.75
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:** $146.35 **Benefit:** 75% = $109.80 85% = $124.40
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) **Fee:** $77.65 **Benefit:** 75% = $58.25 85% = $66.05
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:** $930.50 **Benefit:** 75% = $697.90 85% = $845.80
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:** $465.15 **Benefit:** 75% = $348.90 85% = $395.40
42676	CONJUNCTIVA, biopsy of, as an independent procedure **Fee:** $119.30 **Benefit:** 75% = $89.50 85% = $101.45
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.) **Fee:** $62.90 **Benefit:** 75% = $47.20 85% = $53.50
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO^2 or N^20 (Anaes.) **Fee:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) **Fee:** $124.15 **Benefit:** 75% = $93.15
42686	PTERYGIUM, removal of (Anaes.) **Fee:** $282.20 **Benefit:** 75% = $211.65 85% = $239.90
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) **Fee:** $121.05 **Benefit:** 75% = $90.80 85% = $102.90
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) **Fee:** $285.45 **Benefit:** 75% = $214.10 85% = $242.65
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) **Fee:** $465.15 **Benefit:** 75% = $348.90 85% = $395.40
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:** $613.30 **Benefit:** 75% = $460.00 85% = $528.60

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:** $342.05 **Benefit:** 75% = $256.55 85% = $290.75
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:** $784.40 **Benefit:** 75% = $588.30 85% = $699.70 **Extended Medicare Safety Net Cap:** $117.70
42703	INTRAOCULAR LENS or IRIS PROSTHESIS insertion of, into the posterior chamber with fixation to the iris or sclera (Anaes.) (Assist.) **Fee:** $589.90 **Benefit:** 75% = $442.45 85% = $505.20
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:** $480.65 **Benefit:** 75% = $360.50 85% = $408.60
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:** $939.60 **Benefit:** 75% = $704.70 85% = $854.90 **Extended Medicare Safety Net Cap:** $140.95
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:** $822.00 **Benefit:** 75% = $616.50 85% = $737.30
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:** $930.50 **Benefit:** 75% = $697.90 85% = $845.80
42713	IRIS SUTURING, McCannell technique or similar, for fixation of intraocular lens or repair of iris defect (Anaes.) (Assist.) **Fee:** $387.75 **Benefit:** 75% = $290.85 85% = $329.60
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.) **Fee:** $1,233.05 **Benefit:** 75% = $924.80 85% = $1148.35
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:** $535.20 **Benefit:** 75% = $401.40 85% = $454.95
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:** $1,380.25 **Benefit:** 75% = $1035.20
42731	LIMBAL OR PARS PLANA LENSECTOMY combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Anaes.) (Assist.) **Fee:** $1,566.45 **Benefit:** 75% = $1174.85
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:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65
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:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65 **Extended Medicare Safety Net Cap:** $248.15
Amend 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, 1 or more of, as an independent procedure, for a patient requiring the administration of anaesthetic by a specialist anaesthetist. (Anaes.) (See para TN.8.121 of explanatory notes to this Category) **Fee:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65 **Extended Medicare Safety Net Cap:** $248.15
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:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65 **Extended Medicare Safety Net Cap:** $248.15
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:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65
42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.) **Fee:** $651.50 **Benefit:** 75% = $488.65 85% = $566.80
42744	Needle revision of glaucoma filtration bleb, following glaucoma filtering procedure (Anaes.) **Fee:** $309.95 **Benefit:** 75% = $232.50 85% = $263.50
42746	GLAUCOMA, filtering operation for, where conservative therapies have failed, are likely to fail, or are

	contraindicated (Anaes.) (Assist.) **Fee:** $984.85 **Benefit:** 75% = $738.65
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.) **Fee:** $1,233.05 **Benefit:** 75% = $924.80
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:** $1,380.25 **Benefit:** 75% = $1035.20
42755	GLAUCOMA, removal of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) **Fee:** $170.60 **Benefit:** 75% = $127.95 85% = $145.05
42758	Goniotomy for the treatment of primary congenital glaucoma, excluding the minimally invasive implantation of glaucoma drainage devices (Anaes.) (Assist.) **Fee:** $721.30 **Benefit:** 75% = $541.00
42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $535.20 **Benefit:** 75% = $401.40 85% = $454.95
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $535.20 **Benefit:** 75% = $401.40 85% = $454.95
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) **Fee:** $1,124.40 **Benefit:** 75% = $843.30
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:** $304.00 **Benefit:** 75% = $228.00 85% = $258.40
42773	DETACHED RETINA, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.) **Fee:** $930.50 **Benefit:** 75% = $697.90 85% = $845.80
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) **Fee:** $1,380.25 **Benefit:** 75% = $1035.20
42779	DETACHED RETINA, revision of scleral buckling operation for (Anaes.) (Assist.) **Fee:** $1,721.60 **Benefit:** 75% = $1291.20
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: $465.15 **Benefit:** 75% = $348.90 85% = $395.40
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:** $364.40 **Benefit:** 75% = $273.30 85% = $309.75
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:** $364.40 **Benefit:** 75% = $273.30 85% = $309.75
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:** $364.40 **Benefit:** 75% = $273.30 85% = $309.75
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:** $69.80 **Benefit:** 75% = $52.35 85% = $59.35
42801	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.) **Fee:** $1,082.50 **Benefit:** 75% = $811.90
42802	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.) **Fee:** $541.10 **Benefit:** 75% = $405.85
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:** $604.85 **Benefit:** 75% = $453.65 85% = $520.15
42806	IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.) **Fee:** $364.40 **Benefit:** 75% = $273.30 85% = $309.75
42807	PHOTOMYDRIASIS, laser **Fee:** $366.90 **Benefit:** 75% = $275.20 85% = $311.90
42808	Laser peripheral iridoplasty **Fee:** $366.90 **Benefit:** 75% = $275.20 85% = $311.90
42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) **Fee:** $465.15 **Benefit:** 75% = $348.90 85% = $395.40
42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.)

	Fee: $585.45 **Benefit:** 75% = $439.10 85% = $500.75
42811	TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.) **Fee:** $465.15 **Benefit:** 75% = $348.90 85% = $395.40
42812	Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.) **Fee:** $170.60 **Benefit:** 75% = $127.95 85% = $145.05
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:** $651.50 **Benefit:** 75% = $488.65
42818	RETINA, CRYOTHERAPY TO, as an independent procedure, or when performed in conjunction with item 42809 or 42770 (Anaes.) **Fee:** $604.85 **Benefit:** 75% = $453.65 85% = $520.15
42821	OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.) **Fee:** $93.20 **Benefit:** 75% = $69.90 85% = $79.25
42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure **Fee:** $72.05 **Benefit:** 75% = $54.05 85% = $61.25
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:** $604.85 **Benefit:** 75% = $453.65
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:** $752.20 **Benefit:** 75% = $564.15
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:** $721.30 **Benefit:** 75% = $541.00
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:** $899.55 **Benefit:** 75% = $674.70
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:** $195.35 **Benefit:** 75% = $146.55 85% = $166.05
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or

	over (Anaes.) (Assist.) **Fee:** $721.30 **Benefit:** 75% = $541.00
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:** $899.55 **Benefit:** 75% = $674.70
42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.) **Fee:** $418.75 **Benefit:** 75% = $314.10 85% = $355.95
42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.) **Fee:** $418.75 **Benefit:** 75% = $314.10 85% = $355.95
42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.) **Fee:** $930.50 **Benefit:** 75% = $697.90 85% = $845.80
42863	EYELID, recession of (Anaes.) (Assist.) **Fee:** $798.75 **Benefit:** 75% = $599.10 85% = $714.05
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:** $775.35 **Benefit:** 75% = $581.55 85% = $690.65
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) **Fee:** $566.15 **Benefit:** 75% = $424.65 85% = $481.45
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:** $248.20 **Benefit:** 75% = $186.15 85% = $211.00
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:** $469.30 **Benefit:** 75% = $352.00 85% = $398.95
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:** $563.20 **Benefit:** 75% = $422.40 85% = $478.75
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:** $91.25 **Benefit:** 75% = $68.45 85% = $77.60

T8. SURGICAL OPERATIONS	10. OPERATIONS FOR OSTEOMYELITIS
	Group T8. Surgical Operations
	Subgroup 10. Operations For Osteomyelitis
	ACUTE
43500	OPERATION ON PHALANX (Anaes.) **Fee:** $127.20 **Benefit:** 75% = $95.40
43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.) **Fee:** $211.10 **Benefit:** 75% = $158.35
43506	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65
43509	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65
	CHRONIC
43512	OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65
43515	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65 85% = $312.40
43518	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) **Fee:** $605.95 **Benefit:** 75% = $454.50
43521	OPERATION ON SKULL (Anaes.) (Assist.) **Fee:** $479.05 **Benefit:** 75% = $359.30
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.) **Fee:** $605.95 **Benefit:** 75% = $454.50 85% = $521.25

T8. SURGICAL OPERATIONS	11. PAEDIATRIC
	Group T8. Surgical Operations
	Subgroup 11. Paediatric
	SURGERY IN NEONATE OR YOUNG CHILD
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) **Fee:** $987.20 **Benefit:** 75% = $740.40

	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.)
43804	**Fee:** $1,051.10 **Benefit:** 75% = $788.35
	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, on a person under 10 years of age (Anaes.)
43805	**Fee:** $367.50 **Benefit:** 75% = $275.65
	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.)
43807	**Fee:** $1,146.75 **Benefit:** 75% = $860.10
	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.)
43810	**Fee:** $1,337.85 **Benefit:** 75% = $1003.40
	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.)
43813	**Fee:** $1,337.85 **Benefit:** 75% = $1003.40
	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.)
43816	**Fee:** $1,242.20 **Benefit:** 75% = $931.65
	Agangliosis Coli, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.)
43819	**Fee:** $1,003.35 **Benefit:** 75% = $752.55
	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.)
43822	**Fee:** $1,003.35 **Benefit:** 75% = $752.55
	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.)
43825	**Fee:** $1,146.75 **Benefit:** 75% = $860.10
	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.)
43828	**Fee:** $1,266.90 **Benefit:** 75% = $950.20
	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.)
43831	**Fee:** $987.20 **Benefit:** 75% = $740.40
	BRANCHIAL FISTULA, on a person under 10 years of age. Removal of, (Anaes.) (Assist.)
43832	**Fee:** $673.35 **Benefit:** 75% = $505.05
	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.)
43834	**Fee:** $1,146.75 **Benefit:** 75% = $860.10
43835	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel

	resection, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $698.85 **Benefit:** 75% = $524.15
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.) **Fee:** $1,433.35 **Benefit:** 75% = $1075.05
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 person under 10 years of age (Anaes.) (Assist.) **Fee:** $1,283.35 **Benefit:** 75% = $962.55
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:** $1,242.20 **Benefit:** 75% = $931.65
43841	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 43835 applies, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $622.70 **Benefit:** 75% = $467.05
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:** $1,911.25 **Benefit:** 75% = $1433.45
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:** $2,054.55 **Benefit:** 75% = $1540.95
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) **Fee:** $525.55 **Benefit:** 75% = $394.20
43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) **Fee:** $1,672.20 **Benefit:** 75% = $1254.15
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) **Fee:** $1,767.95 **Benefit:** 75% = $1326.00
43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) **Fee:** $621.10 **Benefit:** 75% = $465.85
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) **Fee:** $1,720.15 **Benefit:** 75% = $1290.15
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.) **Fee:** $1,290.10 **Benefit:** 75% = $967.60
43867	GASTROSCHISIS or Exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.) **Fee:** $716.70 **Benefit:** 75% = $537.55

43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) **Fee:** $1,003.35 **Benefit:** 75% = $752.55
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) **Fee:** $1,337.85 **Benefit:** 75% = $1003.40
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) **Fee:** $1,146.75 **Benefit:** 75% = $860.10
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) **Fee:** $1,337.85 **Benefit:** 75% = $1003.40
43882	CLOACAL EXSTROPHY, operation for (Anaes.) (Assist.) **Fee:** $1,720.15 **Benefit:** 75% = $1290.15 85% = $1635.45
	THORACIC SURGERY
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) **Fee:** $1,146.75 **Benefit:** 75% = $860.10
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) **Fee:** $1,911.25 **Benefit:** 75% = $1433.45
43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) **Fee:** $1,672.20 **Benefit:** 75% = $1254.15
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.) **Fee:** $1,672.20 **Benefit:** 75% = $1254.15
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) **Fee:** $1,579.85 **Benefit:** 75% = $1184.90
43915	EVENTRATION, plication of diaphragm for (Anaes.) (Assist.) **Fee:** $1,194.50 **Benefit:** 75% = $895.90
	ABDOMINAL SURGERY
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) **Fee:** $459.35 **Benefit:** 75% = $344.55
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) **Fee:** $537.70 **Benefit:** 75% = $403.30
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) **Fee:** $1,003.35 **Benefit:** 75% = $752.55
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.)

	(Assist.) **Fee:** $764.45 **Benefit:** 75% = $573.35
43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.) **Fee:** $238.95 **Benefit:** 75% = $179.25
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) **Fee:** $1,003.35 **Benefit:** 75% = $752.55
43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.) **Fee:** $143.45 **Benefit:** 75% = $107.60
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) **Fee:** $898.55 **Benefit:** 75% = $673.95
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,099.05 **Benefit:** 75% = $824.30
43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,194.50 **Benefit:** 75% = $895.90
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.) **Fee:** $420.20 **Benefit:** 75% = $315.15
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.) **Fee:** $1,672.20 **Benefit:** 75% = $1254.15
43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.) **Fee:** $1,911.25 **Benefit:** 75% = $1433.45
43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.) **Fee:** $2,627.95 **Benefit:** 75% = $1971.00
43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.) **Fee:** $1,911.25 **Benefit:** 75% = $1433.45
43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $2,245.75 **Benefit:** 75% = $1684.35
43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.) **Fee:** $1,911.25 **Benefit:** 75% = $1433.45
43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed

	(Anaes.) (Assist.) **Fee:** $525.55 **Benefit:** 75% = $394.20
43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.) **Fee:** $1,337.85 **Benefit:** 75% = $1003.40
43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.) **Fee:** $1,481.30 **Benefit:** 75% = $1111.00
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:** $1,815.75 **Benefit:** 75% = $1361.85
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:** $1,959.00 **Benefit:** 75% = $1469.25
43996	Aganglionosis Coli, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.) **Fee:** $2,197.95 **Benefit:** 75% = $1648.50
43999	Aganglionosis Coli, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) **Fee:** $274.85 **Benefit:** 75% = $206.15
44101	RECTUM, examination of, on a person under 2 years of age, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) **Fee:** $344.50 **Benefit:** 75% = $258.40
44102	RECTUM, examination of, on a person 2 years of age or over, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) **Fee:** $264.95 **Benefit:** 75% = $198.75
44104	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a person under 2 years of age, under general anaesthesia (Anaes.) **Fee:** $60.50 **Benefit:** 75% = $45.40 85% = $51.45
44105	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a person 2 years of age or over, under general anaesthesia (Anaes.) **Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55
44108	INGUINAL HERNIA repair at age less than 12 months (Anaes.) (Assist.) **Fee:** $506.80 **Benefit:** 75% = $380.10
44111	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair, at age, less than 12 months including orchidopexy when performed (Anaes.) (Assist.) **Fee:** $593.60 **Benefit:** 75% = $445.20 85% = $508.90
44114	INGUINAL HERNIA repair at age less than 12 months when orchidopexy also required (Anaes.) (Assist.)

	Fee: $593.60 **Benefit:** 75% = $445.20
	MISCELLANEOUS SURGERY
44130	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) **Fee:** $477.75 **Benefit:** 75% = $358.35 85% = $406.10
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) **Fee:** $379.25 **Benefit:** 75% = $284.45
44136	INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes.) **Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60

	Group T8. Surgical Operations
	Subgroup 12. Amputations
44325	HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.) **Fee:** $304.95 **Benefit:** 75% = $228.75 85% = $259.25
44328	HAND, FOREARM OR THROUGH ARM, amputation of (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65
44331	AMPUTATION AT SHOULDER (Anaes.) (Assist.) **Fee:** $605.95 **Benefit:** 75% = $454.50
44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.) **Fee:** $1,231.55 **Benefit:** 75% = $923.70 85% = $1146.85
44338	1 DIGIT of foot, amputation of (Anaes.) **Fee:** $148.50 **Benefit:** 75% = $111.40 85% = $126.25
44342	2 DIGITS of 1 foot, amputation of (Anaes.) **Fee:** $226.80 **Benefit:** 75% = $170.10
44346	3 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $261.90 **Benefit:** 75% = $196.45
44350	4 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $297.20 **Benefit:** 75% = $222.90 85% = $252.65
44354	5 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $340.15 **Benefit:** 75% = $255.15
44358	TOE, including metatarsal or part of metatarsal each toe , amputation of (Anaes.) **Fee:** $189.65 **Benefit:** 75% = $142.25
44359	ONE OR MORE TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare

T8. SURGICAL OPERATIONS	12. AMPUTATIONS
	(Anaes.) (Assist.) **Fee:** $272.15 **Benefit:** 75% = $204.15
44361	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.) **Fee:** $304.95 **Benefit:** 75% = $228.75
44367	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.) **Fee:** $538.25 **Benefit:** 75% = $403.70
44370	AMPUTATION AT HIP (Anaes.) (Assist.) **Fee:** $742.70 **Benefit:** 75% = $557.05
44373	HINDQUARTER, amputation of (Anaes.) (Assist.) **Fee:** $1,524.60 **Benefit:** 75% = $1143.45 85% = $1439.90
44376	AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.) **Derived Fee:** 75% of the original amputation fee

T8. SURGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Group T8. Surgical Operations
	Subgroup 13. Plastic And Reconstructive Surgery
	GENERAL
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 31376 (Anaes.) **Fee:** $558.25 **Benefit:** 75% = $418.70 85% = $474.55
45003	Single stage local myocutaneous flap repair to one defect, simple and small not in association with any of items 31356 to 31376 (Anaes.) **Fee:** $620.45 **Benefit:** 75% = $465.35 85% = $535.75 **Extended Medicare Safety Net Cap:** $496.40
45006	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.) (Assist.) **Fee:** $1,070.05 **Benefit:** 75% = $802.55
45009	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.) **Fee:** $390.90 **Benefit:** 75% = $293.20
45012	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.) (Assist.) **Fee:** $654.85 **Benefit:** 75% = $491.15
45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.)

	Fee: $310.15 **Benefit:** 75% = $232.65
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:** $488.45 **Benefit:** 75% = $366.35 85% = $415.20
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:** $409.10 **Benefit:** 75% = $306.85
45021	ABRASIVE THERAPY 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:** $182.90 **Benefit:** 75% = $137.20 85% = $155.50
45024	ABRASIVE THERAPY 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:** $411.00 **Benefit:** 75% = $308.25 85% = $349.35
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:** $182.90 **Benefit:** 75% = $137.20 85% = $155.50 **Extended Medicare Safety Net Cap:** $146.35
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:** $411.00 **Benefit:** 75% = $308.25 85% = $349.35 **Extended Medicare Safety Net Cap:** $328.80
45027	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $124.15 **Benefit:** 75% = $93.15 85% = $105.55
45030	ANGIOMA (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes.) **Fee:** $133.25 **Benefit:** 75% = $99.95 85% = $113.30
45033	ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.) **Fee:** $248.20 **Benefit:** 75% = $186.15 85% = $211.00
45035	ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.) **Fee:** $724.00 **Benefit:** 75% = $543.00
45036	ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.) **Fee:** $1,163.30 **Benefit:** 75% = $872.50
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.) **Fee:** $248.20 **Benefit:** 75% = $186.15 85% = $211.00
45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.) **Fee:** $318.05 **Benefit:** 75% = $238.55 85% = $270.35
45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) **Fee:** $318.05 **Benefit:** 75% = $238.55 85% = $270.35
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:** $798.75 **Benefit:** 75% = $599.10
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:** $488.55 **Benefit:** 75% = $366.45
45054	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.) (See para TN.8.92 of explanatory notes to this Category) **Fee:** $253.80 **Benefit:** 75% = $190.35
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:** $1,311.00 **Benefit:** 75% = $983.25
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:** $1,311.00 **Benefit:** 75% = $983.25
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:** $948.70 **Benefit:** 75% = $711.55
	SKIN FLAP SURGERY
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 31376 (Anaes.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $293.25 **Benefit:** 75% = $219.95 85% = $249.30 **Extended Medicare Safety Net Cap:** $234.60
45201	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion (only in association with items 31000, 31001, 31002, 31003, 31004, 31005, 31358, 31359, 31360, 31363, 31364, 31369, 31370, 31371, 31373 or 31376)-may be claimed only once per defect (Anaes.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $426.85 **Benefit:** 75% = $320.15 85% = $362.85
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:** $426.85 **Benefit:** 75% = $320.15 85% = $362.85
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 31376 (Anaes.) (Assist.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $418.75 **Benefit:** 75% = $314.10 85% = $355.95 **Extended Medicare Safety Net Cap:** $335.00
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 31376 (Anaes.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $395.55 **Benefit:** 75% = $296.70 85% = $336.25 **Extended Medicare Safety Net Cap:** $316.45

	H-flap or double advancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead not in association with any of items 31356 to 31376 (Anaes.)
45207	**Fee:** $395.55 **Benefit:** 75% = $296.70 85% = $336.25
	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.)
45209	**Fee:** $488.55 **Benefit:** 75% = $366.45 85% = $415.30
	DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (Anaes.)
45212	**Fee:** $242.40 **Benefit:** 75% = $181.80 85% = $206.05
	DIRECT FLAP REPAIR, cross leg, first stage (Anaes.) (Assist.)
45215	**Fee:** $1,045.70 **Benefit:** 75% = $784.30
	DIRECT FLAP REPAIR, cross leg, second stage (Anaes.) (Assist.)
45218	**Fee:** $469.10 **Benefit:** 75% = $351.85
	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.)
45221	**Fee:** $269.75 **Benefit:** 75% = $202.35 85% = $229.30
	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.)
45224	**Fee:** $121.25 **Benefit:** 75% = $90.95 85% = $103.10
	INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes.) (Assist.)
45227	**Fee:** $459.35 **Benefit:** 75% = $344.55 85% = $390.45
	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.)
45230	**Fee:** $229.70 **Benefit:** 75% = $172.30 85% = $195.25
	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.)
45233	**Fee:** $488.55 **Benefit:** 75% = $366.45 85% = $415.30
	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.)
45236	**Fee:** $383.10 **Benefit:** 75% = $287.35
	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.)
45239	**Fee:** $269.75 **Benefit:** 75% = $202.35 85% = $229.30
	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.)
45240	**Fee:** $269.75 **Benefit:** 75% = $202.35 85% = $229.30
	FREE GRAFTS
	FREE GRAFTING (split skin) of a granulating area, small (Anaes.)
45400	**Fee:** $211.10 **Benefit:** 75% = $158.35 85% = $179.45
	FREE GRAFTING (split skin) of a granulating area, extensive (Anaes.) (Assist.)
45403	**Fee:** $420.20 **Benefit:** 75% = $315.15 85% = $357.20

45406	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (Anaes.) (Assist.) (See para TN.8.94 of explanatory notes to this Category) **Fee:** $465.15 **Benefit:** 75% = $348.90 85% = $395.40
45409	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 3 per cent or more but less than 6 per cent of total body surface (Anaes.) (Assist.) (See para TN.8.94 of explanatory notes to this Category) **Fee:** $620.45 **Benefit:** 75% = $465.35
45412	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (Anaes.) (Assist.) (See para TN.8.94 of explanatory notes to this Category) **Fee:** $853.15 **Benefit:** 75% = $639.90
45415	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 9 per cent or more but less than 12 per cent of total body surface (Anaes.) (Assist.) (See para TN.8.94 of explanatory notes to this Category) **Fee:** $930.50 **Benefit:** 75% = $697.90
45418	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 12 per cent or more but less than 15 per cent of total body surface (Anaes.) (Assist.) (See para TN.8.94 of explanatory notes to this Category) **Fee:** $1,008.10 **Benefit:** 75% = $756.10
45439	FREE GRAFTING (split skin) to 1 defect, including elective dissection, small (Anaes.) **Fee:** $293.25 **Benefit:** 75% = $219.95 85% = $249.30
45442	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.) **Fee:** $604.85 **Benefit:** 75% = $453.65 85% = $520.15
45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of, and removal of mould) (Anaes.) (Assist.) **Fee:** $574.00 **Benefit:** 75% = $430.50 85% = $489.30
45448	FREE GRAFTING (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes.) **Fee:** $387.75 **Benefit:** 75% = $290.85 85% = $329.60
45451	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.) **Fee:** $488.55 **Benefit:** 75% = $366.45 85% = $415.30
45460	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *15 percent or more but less than 20 percent* of total body surface - one surgeon (Anaes.) (Assist.) **Fee:** $1,292.45 **Benefit:** 75% = $969.35
45461	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *15 percent or more but less than 20 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $921.15 **Benefit:** 75% = $690.90

45462	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *15 percent or more but less than 20 percent* of total body surface - conjoint surgery, co- surgeon (Assist.) **Fee:** $695.10 **Benefit:** 75% = $521.35
45464	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *20 percent or more but less than 30 percent* of total body surface - one surgeon (Anaes.) (Assist.) **Fee:** $1,972.85 **Benefit:** 75% = $1479.65
45465	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *20 percent or more but less than 30 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $1,405.55 **Benefit:** 75% = $1054.20 85% = $1320.85
45466	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *20 percent or more but less than 30 percent* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,060.05 **Benefit:** 75% = $795.05 85% = $975.35
45468	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *30 percent or more but less than 40 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $1,889.90 **Benefit:** 75% = $1417.45
45469	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *30 percent or more but less than 40 percent* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,425.85 **Benefit:** 75% = $1069.40 85% = $1341.15
45471	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *40 percent or more but less than 50 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,375.60 **Benefit:** 75% = $1781.70 85% = $2290.90
45472	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *40 percent or more but less than 50 percent* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,791.90 **Benefit:** 75% = $1343.95 85% = $1707.20
45474	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *50 percent or more but less than 60 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,859.90 **Benefit:** 75% = $2144.95 85% = $2775.20
45475	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *50 percent or more but less than 60 percent* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $2,157.85 **Benefit:** 75% = $1618.40 85% = $2073.15
45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *60 percent or more but less than 70 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $3,344.30 **Benefit:** 75% = $2508.25 85% = $3259.60
45478	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *60 percent or*

	more but less than 70 percent of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $2,522.50 **Benefit:** 75% = $1891.90 85% = $2437.80
45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *70 percent or more but less than 80 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $3,828.60 **Benefit:** 75% = $2871.45 85% = $3743.90
45481	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *70 percent or more but less than 80 percent* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $2,888.60 **Benefit:** 75% = $2166.45 85% = $2803.90
45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *80 percent or more* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $4,362.10 **Benefit:** 75% = $3271.60 85% = $4277.40
45484	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *80 percent or more* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $3,291.20 **Benefit:** 75% = $2468.40 85% = $3206.50
45485	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes.) (Assist.) **Fee:** $544.20 **Benefit:** 75% = $408.15
45486	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.) **Fee:** $465.15 **Benefit:** 75% = $348.90
45487	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.) (Assist.) **Fee:** $418.75 **Benefit:** 75% = $314.10 85% = $355.95
45488	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.) **Fee:** $465.15 **Benefit:** 75% = $348.90
45489	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.) **Fee:** $697.95 **Benefit:** 75% = $523.50 85% = $613.25
45490	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.) **Fee:** $930.70 **Benefit:** 75% = $698.05
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.) (Assist.) **Fee:** $1,163.30 **Benefit:** 75% = $872.50
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.)

	Fee: $1,395.90 **Benefit:** 75% = $1046.95
45493	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.) (Assist.) **Fee:** $418.75 **Benefit:** 75% = $314.10
45494	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.) **Fee:** $1,689.85 **Benefit:** 75% = $1267.40 85% = $1605.15
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
45496	FLAP, free tissue transfer using microvascular techniques - *revision of*, by open operation (Anaes.) **Fee:** $429.05 **Benefit:** 75% = $321.80
45497	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - *complete revision of*, by liposuction (Anaes.) **Fee:** $335.10 **Benefit:** 75% = $251.35
45498	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - *staged revision of*, by liposuction - first stage (Anaes.) **Fee:** $269.75 **Benefit:** 75% = $202.35
45499	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - *staged revision of*, by liposuction - second stage (Anaes.) **Fee:** $201.05 **Benefit:** 75% = $150.80
45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) **Fee:** $1,124.40 **Benefit:** 75% = $843.30
45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) **Fee:** $1,830.15 **Benefit:** 75% = $1372.65
45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) **Fee:** $1,830.15 **Benefit:** 75% = $1372.65
45503	MICRO-ARTERIAL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.) **Fee:** $2,093.80 **Benefit:** 75% = $1570.35
45504	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) **Fee:** $1,830.15 **Benefit:** 75% = $1372.65
45505	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) **Fee:** $1,830.15 **Benefit:** 75% = $1372.65
45506	SCAR, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating

	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:** $226.80 **Benefit:** 75% = $170.10 85% = $192.80
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:** $304.95 **Benefit:** 75% = $228.75 85% = $259.25
45515	SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or where performed by a specialist in the practice of his or her specialty (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $192.35 **Benefit:** 75% = $144.30 85% = $163.50
45518	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her speciality (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $232.75 **Benefit:** 75% = $174.60 85% = $197.85
45519	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.) **Fee:** $442.45 **Benefit:** 75% = $331.85
45520	Reduction mammaplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast (Anaes.) (Assist.) **Fee:** $928.55 **Benefit:** 75% = $696.45
45522	Reduction mammaplasty (unilateral) without surgical repositioning of the nipple: (a) excluding the treatment of gynaecomastia; and (b) not with insertion of any prosthesis (Anaes.) (Assist.) **Fee:** $651.50 **Benefit:** 75% = $488.65
45523	Reduction mammaplasty (bilateral) with surgical repositioning of the nipple: (a) for patients with macromastia and experiencing pain in the neck or shoulder region; and (b) not with insertion of any prosthesis (Anaes.) (Assist.) **Fee:** $1,392.90 **Benefit:** 75% = $1044.70
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 (Anaes.) (Assist.) (See para TN.8.96 of explanatory notes to this Category) **Fee:** $764.80 **Benefit:** 75% = $573.60
45527	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis (Anaes.) (Assist.) (See para TN.8.96 of explanatory notes to this Category) **Fee:** $764.80 **Benefit:** 75% = $573.60
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 and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) (See para TN.8.96 of explanatory notes to this Category) **Fee:** $1,147.10 **Benefit:** 75% = $860.35
45530	Breast reconstruction (unilateral), using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177 or 30179 applies (H) (Anaes.) (Assist.) (See para TN.8.97 of explanatory notes to this Category) **Fee:** $1,133.75 **Benefit:** 75% = $850.35
45533	BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $1,283.95 **Benefit:** 75% = $963.00
45536	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.) **Fee:** $472.20 **Benefit:** 75% = $354.15
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) **Fee:** $1,104.70 **Benefit:** 75% = $828.55
45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.) **Fee:** $632.55 **Benefit:** 75% = $474.45

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:** $642.00 **Benefit:** 75% = $481.50 85% = $557.30 **Extended Medicare Safety Net Cap:** $513.60
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
45548	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.) **Fee:** $285.45 **Benefit:** 75% = $214.10 85% = $242.65
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.) **Fee:** $457.55 **Benefit:** 75% = $343.20
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 of explanatory notes to this Category) **Fee:** $589.45 **Benefit:** 75% = $442.10
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 of explanatory notes to this Category) **Fee:** $721.30 **Benefit:** 75% = $541.00

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 (Anaes.) (Assist.) (See para TN.8.99 of explanatory notes to this Category) **Fee:** $789.95 **Benefit:** 75% = $592.50
45558	Breast ptosis, correction by mastopexy of (bilateral), if: (a) 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; and (b) if the patient has been pregnant—the correction is performed not less than 1 year, or more than 7 years, after completion of the most recent pregnancy of the patient; and (c) 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 (Anaes.) (Assist.) (See para TN.8.99 of explanatory notes to this Category) **Fee:** $1,184.85 **Benefit:** 75% = $888.65
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:** $488.45 **Benefit:** 75% = $366.35 85% = $415.20 **Extended Medicare Safety Net Cap:** $171.00
45561	MICROVASCULAR ANASTOMOSIS of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (Anaes.) (Assist.) **Fee:** $1,830.15 **Benefit:** 75% = $1372.65
45562	FREE TRANSFER OF TISSUE involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $1,133.75 **Benefit:** 75% = $850.35 85% = $1049.05
45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $1,133.75 **Benefit:** 75% = $850.35 85% = $1049.05
45564	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies-conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $2,625.85 **Benefit:** 75% = $1969.40

45565	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies-conjoint surgery, conjoint specialist surgeon (H) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $1,969.45 **Benefit:** 75% = $1477.10
45566	TISSUE EXPANSION not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) **Fee:** $1,104.70 **Benefit:** 75% = $828.55
45568	TISSUE EXPANDER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20
45569	CLOSURE OF ABDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.) **Fee:** $698.80 **Benefit:** 75% = $524.10
45570	CLOSURE OF ABDOMEN, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.) **Fee:** $943.55 **Benefit:** 75% = $707.70 85% = $858.85
45572	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.) **Fee:** $300.80 **Benefit:** 75% = $225.60 85% = $255.70
45575	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.) **Fee:** $742.70 **Benefit:** 75% = $557.05 85% = $658.00
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.) **Fee:** $860.10 **Benefit:** 75% = $645.10
45581	FACIAL NERVE PALSY, excision of tissue for (Anaes.) **Fee:** $285.45 **Benefit:** 75% = $214.10 85% = $242.65
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.8.8, TN.8.101 of explanatory notes to this Category) **Fee:** $651.50 **Benefit:** 75% = $488.65
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 applies, if: (a) the liposuction is for: (i) the treatment of Barraquer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or

	(ii) the reduction of a buffalo hump that is secondary to an endocrine disorder or pharmacological treatment of a medical condition; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.8, TN.8.101 of explanatory notes to this Category) **Fee:** $651.50 **Benefit:** 75% = $488.65
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:** $918.70 **Benefit:** 75% = $689.05
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:** $1,378.15 **Benefit:** 75% = $1033.65
45590	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.) **Fee:** $498.35 **Benefit:** 75% = $373.80
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) **Fee:** $585.40 **Benefit:** 75% = $439.05
45596	MAXILLA, total resection of (Anaes.) (Assist.) **Fee:** $928.55 **Benefit:** 75% = $696.45
45597	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) **Fee:** $1,243.05 **Benefit:** 75% = $932.30
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) **Fee:** $965.80 **Benefit:** 75% = $724.35 85% = $881.10
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $721.30 **Benefit:** 75% = $541.00
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $605.95 **Benefit:** 75% = $454.50
45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a

	service to which item 45599 applies (Anaes.) (Assist.) **Fee:** $853.15 **Benefit:** 75% = $639.90
45611	MANDIBLE, condylectomy (Anaes.) (Assist.) **Fee:** $488.55 **Benefit:** 75% = $366.45
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.) **Fee:** $605.95 **Benefit:** 75% = $454.50 85% = $521.25 **Extended Medicare Safety Net Cap:** $484.80
45617	Upper eyelid, reduction of, if: (a) the reduction is for any of the following: (i) skin redundancy that causes a visual field defect (confirmed by an optometrist or ophthalmologist) or intertriginous inflammation of the eyelid; (ii) herniation of orbital fat in exophthalmos; (iii) facial nerve palsy; (iv) post-traumatic scarring; (v) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions mentioned in subparagraphs (i) to (iv); 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:** $242.40 **Benefit:** 75% = $181.80 85% = $206.05 **Extended Medicare Safety Net Cap:** $193.95
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:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80 **Extended Medicare Safety Net Cap:** $269.00
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:** $745.60 **Benefit:** 75% = $559.20 85% = $660.90 **Extended Medicare Safety Net Cap:** $596.50
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:** $966.70 **Benefit:** 75% = $725.05 85% = $882.00 **Extended Medicare Safety Net Cap:** $773.40
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:** $193.40 **Benefit:** 75% = $145.05
45626	Ectropion or entropion, not caused by trachoma, correction of (unilateral) (Anaes.) **Fee:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80
45627 S	Ectropion or entropion, caused by trachoma, correction of (unilateral) (Anaes.) **Fee:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80
45629	SYMBLEPHARON, grafting for (Anaes.) (Assist.) **Fee:** $488.55 **Benefit:** 75% = $366.45 85% = $415.30
45632	Rhinoplasty, partial, involving correction of lateral or alar cartilages, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $527.95 **Benefit:** 75% = $396.00 85% = $448.80 **Extended Medicare Safety Net Cap:** $422.40
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:** $605.95 **Benefit:** 75% = $454.50 85% = $521.25 **Extended Medicare Safety Net Cap:** $484.80
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:** $1,099.30 **Benefit:** 75% = $824.50
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 (Anaes.) (Assist.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $1,319.40 **Benefit:** 75% = $989.55
45645	CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes.) **Fee:** $230.60 **Benefit:** 75% = $172.95
45646	CHOANAL ATRESIA - correction by open operation with bone removal (Anaes.) (Assist.) **Fee:** $928.55 **Benefit:** 75% = $696.45 85% = $843.85
45647	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.) (See para TN.8.105 of explanatory notes to this Category) **Fee:** $1,319.40 **Benefit:** 75% = $989.55
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:** $152.40 **Benefit:** 75% = $114.30 85% = $129.55
45652	Rhinophyma of a moderate or severe degree, carbon dioxide laser or erbium laser excision - ablation of (Anaes.) **Fee:** $367.50 **Benefit:** 75% = $275.65 85% = $312.40 **Extended Medicare Safety Net Cap:** $294.00
45653	RHINOPHYMA, shaving of (Anaes.) **Fee:** $367.50 **Benefit:** 75% = $275.65 85% = $312.40
45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $517.95 **Benefit:** 75% = $388.50 85% = $440.30
New 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:** $537.55 **Benefit:** 75% = $403.20
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:** $537.55 **Benefit:** 75% = $403.20
45660	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, 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 his or her specialty (Anaes.) (Assist.) **Fee:** $2,968.65 **Benefit:** 75% = $2226.50
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 full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) **Fee:** $1,319.40 **Benefit:** 75% = $989.55
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.) **Fee:** $723.20 **Benefit:** 75% = $542.40

45665	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes.) **Fee:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80
45668	VERMILIONECTOMY, by surgical excision (Anaes.) **Fee:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80
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:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80
45671	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $860.10 **Benefit:** 75% = $645.10 85% = $775.40
45674	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $250.15 **Benefit:** 75% = $187.65 85% = $212.65
45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $498.35 **Benefit:** 75% = $373.80
45676	MACROSTOMIA, operation for (Anaes.) (Assist.) **Fee:** $593.25 **Benefit:** 75% = $444.95
45677	CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $558.25 **Benefit:** 75% = $418.70
45680	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $697.95 **Benefit:** 75% = $523.50
45683	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $775.35 **Benefit:** 75% = $581.55
45686	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $915.25 **Benefit:** 75% = $686.45
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $269.95 **Benefit:** 75% = $202.50
45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) **Fee:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $504.00 **Benefit:** 75% = $378.00
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.)

	Fee: $473.10 **Benefit:** 75% = $354.85
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $853.15 **Benefit:** 75% = $639.90
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $310.15 **Benefit:** 75% = $232.65 85% = $263.65
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $806.35 **Benefit:** 75% = $604.80
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) **Fee:** $504.00 **Benefit:** 75% = $378.00
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $574.00 **Benefit:** 75% = $430.50
45714	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.) **Fee:** $806.35 **Benefit:** 75% = $604.80
45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $806.35 **Benefit:** 75% = $604.80
45720	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and excluding services to which item 47933or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $997.00 **Benefit:** 75% = $747.75 85% = $912.30
45723	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,124.40 **Benefit:** 75% = $843.30
45726	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,270.55 **Benefit:** 75% = $952.95
45729	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,426.90 **Benefit:** 75% = $1070.20
45731	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the

	1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,446.55 **Benefit:** 75% = $1084.95
45732	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,628.50 **Benefit:** 75% = $1221.40
45735	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,661.40 **Benefit:** 75% = $1246.05
45738	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,869.00 **Benefit:** 75% = $1401.75
45741	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,827.65 **Benefit:** 75% = $1370.75
45744	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $2,054.95 **Benefit:** 75% = $1541.25
45747	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,993.95 **Benefit:** 75% = $1495.50 85% = $1909.25
45752	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)

	(See para TN.8.107 of explanatory notes to this Category) **Fee:** $2,233.40 **Benefit:** 75% = $1675.05
45753	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III(Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) **Fee:** $2,246.65 **Benefit:** 75% = $1685.00 85% = $2161.95
45754	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) **Fee:** $2,693.20 **Benefit:** 75% = $2019.90
45755	TEMPOROMANDIBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.) **Fee:** $379.25 **Benefit:** 75% = $284.45 85% = $322.40
45758	TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.) **Fee:** $678.65 **Benefit:** 75% = $509.00
45761	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para TN.8.108 of explanatory notes to this Category) **Fee:** $772.05 **Benefit:** 75% = $579.05
45767	HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.) **Fee:** $2,590.15 **Benefit:** 75% = $1942.65 85% = $2505.45
45770	HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.) **Fee:** $1,984.00 **Benefit:** 75% = $1488.00
45773	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes.) (Assist.) **Fee:** $1,808.15 **Benefit:** 75% = $1356.15 85% = $1723.45
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.) **Fee:** $1,808.15 **Benefit:** 75% = $1356.15
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.) **Fee:** $1,329.45 **Benefit:** 75% = $997.10
45782	FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.) **Fee:** $1,016.45 **Benefit:** 75% = $762.35 85% = $931.75
45785	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral frontoorbital advancement) (Anaes.) (Assist.) **Fee:** $1,720.20 **Benefit:** 75% = $1290.15
45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF,

	(Obwegeser technique) (Anaes.) (Assist.) **Fee:** $1,700.65 **Benefit:** 75% = $1275.50
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $918.70 **Benefit:** 75% = $689.05
45794	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.) **Fee:** $519.60 **Benefit:** 75% = $389.70 85% = $441.70
45797	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.) **Fee:** $192.35 **Benefit:** 75% = $144.30 85% = $163.50
	ORAL AND MAXILLOFACIAL SURGERY
45799	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) **Fee:** $30.35 **Benefit:** 75% = $22.80 85% = $25.80
45801	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation),in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 45803 applies (Anaes.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $130.90 **Benefit:** 75% = $98.20 85% = $111.30
45803	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80
45805	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $177.90 **Benefit:** 75% = $133.45 85% = $151.25
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:** $254.20 **Benefit:** 75% = $190.65 85% = $216.10
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:** $383.10 **Benefit:** 75% = $287.35 85% = $325.65
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:** $517.95 **Benefit:** 75% = $388.50 85% = $440.30
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:** $605.95 **Benefit:** 75% = $454.50 85% = $521.25
45815	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) **Fee:** $367.50 **Benefit:** 75% = $275.65 85% = $312.40
45817	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) **Fee:** $479.05 **Benefit:** 75% = $359.30 85% = $407.20
45819	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 45817 (Anaes.) (Assist.) **Fee:** $605.90 **Benefit:** 75% = $454.45 85% = $521.20
45821	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.) **Fee:** $392.70 **Benefit:** 75% = $294.55 85% = $333.80
45823	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $112.30 **Benefit:** 75% = $84.25
45825	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $348.90 **Benefit:** 75% = $261.70 85% = $296.60
45827	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) **Fee:** $333.50 **Benefit:** 75% = $250.15 85% = $283.50
45829	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $254.40 **Benefit:** 75% = $190.80 85% = $216.25
45831	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) **Fee:** $333.50 **Benefit:** 75% = $250.15 85% = $283.50
45833	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) **Fee:** $418.75 **Benefit:** 75% = $314.10 85% = $355.95

45835	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) **Fee:** $519.60 **Benefit:** 75% = $389.70 85% = $441.70
45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $604.85 **Benefit:** 75% = $453.65 85% = $520.15
45839	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) **Fee:** $604.85 **Benefit:** 75% = $453.65 85% = $520.15
45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $488.45 **Benefit:** 75% = $366.35 85% = $415.20
45843	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) **Fee:** $299.60 **Benefit:** 75% = $224.70 85% = $254.70
45845	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $519.60 **Benefit:** 75% = $389.70 85% = $441.70
45847	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $192.35 **Benefit:** 75% = $144.30 85% = $163.50
45849	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) **Fee:** $599.05 **Benefit:** 75% = $449.30 85% = $514.35
45851	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) **Fee:** $147.45 **Benefit:** 75% = $110.60
45853	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $918.70 **Benefit:** 75% = $689.05 85% = $834.00
45855	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) **Fee:** $421.50 **Benefit:** 75% = $316.15 85% = $358.30
45857	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Anaes.) (Assist.) **Fee:** $674.20 **Benefit:** 75% = $505.65 85% = $589.50
45859	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)

	Fee: $339.85 **Benefit:** 75% = $254.90 85% = $288.90
45861	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $899.55 **Benefit:** 75% = $674.70 85% = $814.85
45863	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $997.20 **Benefit:** 75% = $747.90 85% = $912.50
45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $299.60 **Benefit:** 75% = $224.70 85% = $254.70
45867	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $322.05 **Benefit:** 75% = $241.55 85% = $273.75
45869	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,225.30 **Benefit:** 75% = $919.00 85% = $1140.60
45871	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,380.25 **Benefit:** 75% = $1035.20 85% = $1295.55
45873	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,551.00 **Benefit:** 75% = $1163.25 85% = $1466.30
45875	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $485.40 **Benefit:** 75% = $364.05 85% = $412.60
45877	TEMPOROMANDIBULAR JOINT, arthrodesis of, with synovectomy if performed, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $485.40 **Benefit:** 75% = $364.05 85% = $412.60
45879	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $322.05 **Benefit:** 75% = $241.55 85% = $273.75
45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser. **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70
45885	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Anaes.) (Assist.)

	Fee: $457.55 **Benefit:** 75% = $343.20 85% = $388.95
45888	FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $426.45 **Benefit:** 75% = $319.85 85% = $362.50
45891	SINGLE-STAGE LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) **Fee:** $621.30 **Benefit:** 75% = $466.00 85% = $536.60
45894	FREE GRAFTING, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area (Anaes.) **Fee:** $211.10 **Benefit:** 75% = $158.35 85% = $179.45
45897	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) **Fee:** $1,102.50 **Benefit:** 75% = $826.90 85% = $1017.80
45900	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity **Fee:** $248.65 **Benefit:** 75% = $186.50 85% = $211.40
45939	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) **Fee:** $461.05 **Benefit:** 75% = $345.80 85% = $391.90
45945	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
45975	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting (See para TN.8.110 of explanatory notes to this Category) **Fee:** $133.20 **Benefit:** 75% = $99.90 85% = $113.25
45978	MANDIBLE, treatment of fracture of, not requiring splinting (See para TN.8.110 of explanatory notes to this Category) **Fee:** $162.80 **Benefit:** 75% = $122.10 85% = $138.40
45981	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction (See para TN.8.110 of explanatory notes to this Category) **Fee:** $88.30 **Benefit:** 75% = $66.25 85% = $75.10
45984	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Anaes.) (Assist.) (See para TN.8.110 of explanatory notes to this Category) **Fee:** $635.90 **Benefit:** 75% = $476.95 85% = $551.20
45987	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) (See para TN.8.110 of explanatory notes to this Category) **Fee:** $635.90 **Benefit:** 75% = $476.95 85% = $551.20
45990	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring

	open reduction involving the use of plate(s) (Anaes.) (Assist.) (See para TN.8.110 of explanatory notes to this Category) **Fee:** $868.60 **Benefit:** 75% = $651.45 85% = $783.90
45993	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) (See para TN.8.110 of explanatory notes to this Category) **Fee:** $868.60 **Benefit:** 75% = $651.45 85% = $783.90
45996	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) (See para TN.8.110 of explanatory notes to this Category) **Fee:** $246.25 **Benefit:** 75% = $184.70 85% = $209.35

	Group T8. Surgical Operations
	Subgroup 14. Hand Surgery
	Note: Items 46300 to 46534 are restricted to surgery on the hand/s.
46300	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $348.95 **Benefit:** 75% = $261.75
46303	CARPOMETACARPAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $387.85 **Benefit:** 75% = $290.90
46306	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) **Fee:** $542.90 **Benefit:** 75% = $407.20
46307	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) **Fee:** $542.90 **Benefit:** 75% = $407.20
46309	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.) (Assist.) **Fee:** $542.90 **Benefit:** 75% = $407.20
46312	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.) **Fee:** $698.10 **Benefit:** 75% = $523.60
46315	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes.) (Assist.)

	Fee: $930.75 **Benefit:** 75% = $698.10
46318	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes.) (Assist.) **Fee:** $1,163.50 **Benefit:** 75% = $872.65
46321	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Anaes.) (Assist.) **Fee:** $1,396.20 **Benefit:** 75% = $1047.15 85% = $1311.50
46324	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.) **Fee:** $832.55 **Benefit:** 75% = $624.45
46325	CARPAL BONE REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Anaes.) (Assist.) **Fee:** $868.85 **Benefit:** 75% = $651.65
46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.) **Fee:** $209.50 **Benefit:** 75% = $157.15 85% = $178.10
46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular repair with or without arthrotomy (Anaes.) (Assist.) **Fee:** $356.90 **Benefit:** 75% = $267.70
46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes.) (Assist.) **Fee:** $581.65 **Benefit:** 75% = $436.25
46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any procedure related to that joint (Anaes.) (Assist.) **Fee:** $271.50 **Benefit:** 75% = $203.65 85% = $230.80
46339	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.) **Fee:** $480.75 **Benefit:** 75% = $360.60 85% = $408.65
46342	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (Anaes.) (Assist.) **Fee:** $480.75 **Benefit:** 75% = $360.60
46345	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.) **Fee:** $581.65 **Benefit:** 75% = $436.25
46348	DIGIT, synovectomy of flexor tendon or tendons - 1 digit (Anaes.) **Fee:** $252.10 **Benefit:** 75% = $189.10 85% = $214.30
46351	DIGIT, synovectomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.)

	Fee: $376.20 **Benefit:** 75% = $282.15
46354	DIGIT, synovectomy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.) **Fee:** $504.10 **Benefit:** 75% = $378.10
46357	DIGIT, synovectomy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.) **Fee:** $628.25 **Benefit:** 75% = $471.20
46360	DIGIT, synovectomy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.) **Fee:** $756.30 **Benefit:** 75% = $567.25
46363	TENDON SHEATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS (Anaes.) **Fee:** $217.15 **Benefit:** 75% = $162.90 85% = $184.60
46366	DUPUYTREN'S CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.) **Fee:** $131.90 **Benefit:** 75% = $98.95 85% = $112.15
46369	DUPUYTREN'S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.) **Fee:** $217.15 **Benefit:** 75% = $162.90 85% = $184.60
46372	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $441.30 **Benefit:** 75% = $331.00 85% = $375.15
46375	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $523.55 **Benefit:** 75% = $392.70 85% = $445.05
46378	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $698.10 **Benefit:** 75% = $523.60
46381	INTER-PHALANGEAL JOINT, joint capsule release when performed in conjunction with operation for Dupuytren's Contracture - each procedure (Anaes.) (Assist.) **Fee:** $310.20 **Benefit:** 75% = $232.65
46384	Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture - 1 such procedure (Anaes.) (Assist.) **Fee:** $310.20 **Benefit:** 75% = $232.65
46387	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Anaes.) (Assist.) **Fee:** $640.00 **Benefit:** 75% = $480.00 85% = $555.30
46390	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) **Fee:** $853.35 **Benefit:** 75% = $640.05
46393	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of

	nerves - operation for recurrence in those rays (Anaes.) (Assist.) **Fee:** $988.95 **Benefit:** 75% = $741.75
46396	PHALANX OR METACARPAL OF THE HAND, osteotomy or osteectomy of, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $339.85 **Benefit:** 75% = $254.90 85% = $288.90
46399	PHALANX OR METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.) (Assist.) **Fee:** $534.00 **Benefit:** 75% = $400.50
46402	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes.) (Assist.) **Fee:** $534.00 **Benefit:** 75% = $400.50
46405	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes.) (Assist.) **Fee:** $651.65 **Benefit:** 75% = $488.75
46408	TENDON, reconstruction of, by tendon graft (Anaes.) (Assist.) **Fee:** $713.60 **Benefit:** 75% = $535.20
46411	FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes.) (Assist.) **Fee:** $418.85 **Benefit:** 75% = $314.15
46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.) (Assist.) **Fee:** $542.80 **Benefit:** 75% = $407.10 85% = $461.40
46417	TENDON transfer for restoration of hand function, each transfer (Anaes.) (Assist.) **Fee:** $504.10 **Benefit:** 75% = $378.10
46420	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.) **Fee:** $210.95 **Benefit:** 75% = $158.25 85% = $179.35
46423	EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $286.80
46426	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $348.95 **Benefit:** 75% = $261.75
46429	FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $426.55 **Benefit:** 75% = $319.95 85% = $362.60
46432	FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $465.45 **Benefit:** 75% = $349.10

46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $542.90 **Benefit:** 75% = $407.20
46438	MALLET FINGER, closed pin fixation of (Anaes.) **Fee:** $139.65 **Benefit:** 75% = $104.75 85% = $118.75
46441	MALLET FINGER, open repair of, including pin fixation when performed (Anaes.) (Assist.) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $286.80
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.) **Fee:** $289.65 **Benefit:** 75% = $217.25
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.) **Fee:** $504.10 **Benefit:** 75% = $378.10
46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.) **Fee:** $628.25 **Benefit:** 75% = $471.20
46450	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) **Fee:** $232.75 **Benefit:** 75% = $174.60
46453	FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.) **Fee:** $387.85 **Benefit:** 75% = $290.90
46456	FINGER, percutaneous tenotomy of (Anaes.) **Fee:** $100.85 **Benefit:** 75% = $75.65 85% = $85.75
46459	OPERATION for OSTEOMYELITIS on distal phalanx (Anaes.) **Fee:** $193.90 **Benefit:** 75% = $145.45 85% = $164.85
46462	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.) **Fee:** $310.20 **Benefit:** 75% = $232.65 85% = $263.70
46464	AMPUTATION of a supernumerary complete digit (Anaes.) **Fee:** $232.75 **Benefit:** 75% = $174.60 85% = $197.85
46465	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) **Fee:** $232.75 **Benefit:** 75% = $174.60 85% = $197.85
46468	AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $407.20 **Benefit:** 75% = $305.40
46471	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $581.65 **Benefit:** 75% = $436.25 85% = $496.95

46474	AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $756.30 **Benefit:** 75% = $567.25
46477	AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $930.75 **Benefit:** 75% = $698.10
46480	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.) **Fee:** $387.85 **Benefit:** 75% = $290.90 85% = $329.70
46483	REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.) **Fee:** $310.20 **Benefit:** 75% = $232.65 85% = $263.70
46486	NAIL BED, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $232.75 **Benefit:** 75% = $174.60
46489	NAIL BED, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $271.50 **Benefit:** 75% = $203.65
46492	CONTRACTURE OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Anaes.) (Assist.) **Fee:** $372.35 **Benefit:** 75% = $279.30
46494	GANGLION OF HAND, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $226.80 **Benefit:** 75% = $170.10 85% = $192.80
46495	GANGLION OR MUCOUS CYST OF DISTAL DIGIT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) **Fee:** $209.50 **Benefit:** 75% = $157.15 85% = $178.10
46498	GANGLION OF FLEXOR TENDON SHEATH, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) **Fee:** $226.80 **Benefit:** 75% = $170.10 85% = $192.80
46500	GANGLION OF DORSAL WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) **Fee:** $271.50 **Benefit:** 75% = $203.65 85% = $230.80
46501	GANGLION OF VOLAR WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) **Fee:** $339.45 **Benefit:** 75% = $254.60 85% = $288.55
46502	RECURRENT GANGLION OF DORSAL WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) **Fee:** $312.40 **Benefit:** 75% = $234.30 85% = $265.55

T8. SURGICAL OPERATIONS	14. HAND SURGERY
46503	RECURRENT GANGLION OF VOLAR WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) **Fee:** $390.20 **Benefit:** 75% = $292.65 85% = $331.70
46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.) **Fee:** $1,140.10 **Benefit:** 75% = $855.10 85% = $1055.40
46507	DIGIT OR RAY, transposition or transfer of, on vascular pedicle, complete procedure (Anaes.) (Assist.) **Fee:** $1,326.40 **Benefit:** 75% = $994.80
46510	MACRODACTYLY, surgical reduction of enlarged elements - each digit (Anaes.) (Assist.) **Fee:** $361.95 **Benefit:** 75% = $271.50
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies (Anaes.) **Fee:** $58.25 **Benefit:** 75% = $43.70 85% = $49.55
46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $116.35 **Benefit:** 75% = $87.30
46519	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes.) **Fee:** $145.65 **Benefit:** 75% = $109.25 85% = $123.85
46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB, open operation and drainage for infection (Anaes.) (Assist.) **Fee:** $434.35 **Benefit:** 75% = $325.80
46525	PULP SPACE INFECTION, PARONYCHIA OF HAND, incision for, when performed in an operating theatre of a hospital, not being a service to which another item in this Group applies (excluding after-care) (Anaes.) **Fee:** $58.25 **Benefit:** 75% = $43.70 85% = $49.55
46528	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.) **Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60
46531	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) **Fee:** $87.80 **Benefit:** 75% = $65.85 85% = $74.65
46534	NAIL PLATE INJURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes.) **Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45

T8. SURGICAL OPERATIONS	15. ORTHOPAEDIC
	Group T8. Surgical Operations
	Subgroup 15. Orthopaedic

	TREATMENT OF DISLOCATIONS
47000	MANDIBLE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $72.90 **Benefit:** 75% = $54.70 85% = $62.00
47003	CLAVICLE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $87.45 **Benefit:** 75% = $65.60 85% = $74.35
47006	CLAVICLE, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $175.55 **Benefit:** 75% = $131.70 85% = $149.25
47009	SHOULDER, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.) **Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60
47012	SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.) (Assist.) **Fee:** $349.40 **Benefit:** 75% = $262.05
47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia **Fee:** $87.45 **Benefit:** 75% = $65.60 85% = $74.35
47018	ELBOW, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47021	ELBOW, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $271.80 **Benefit:** 75% = $203.85
47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47027	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) (Assist.) **Fee:** $271.80 **Benefit:** 75% = $203.85
47030	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47033	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $87.45 **Benefit:** 75% = $65.60 85% = $74.35
47039	INTERPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90

	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)
47042	**Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90
	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)
47045	**Fee:** $155.45 **Benefit:** 75% = $116.60 85% = $132.15
	HIP, treatment of dislocation of, by closed reduction (Anaes.)
47048	**Fee:** $334.95 **Benefit:** 75% = $251.25 85% = $284.75
	HIP, treatment of dislocation of, by open reduction (Anaes.) (Assist.)
47051	**Fee:** $446.50 **Benefit:** 75% = $334.90
	KNEE, treatment of dislocation of, by closed reduction (Anaes.) (Assist.)
47054	**Fee:** $334.95 **Benefit:** 75% = $251.25 85% = $284.75
	PATELLA, treatment of dislocation of, by closed reduction (Anaes.)
47057	**Fee:** $131.00 **Benefit:** 75% = $98.25 85% = $111.35
	PATELLA, treatment of dislocation of, by open reduction (Anaes.)
47060	**Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60
	ANKLE or TARSUS, treatment of dislocation of, by closed reduction (Anaes.)
47063	**Fee:** $262.10 **Benefit:** 75% = $196.60 85% = $222.80
	ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.)
47066	**Fee:** $349.40 **Benefit:** 75% = $262.05
	TOE, treatment of dislocation of, by closed reduction (Anaes.)
47069	**Fee:** $72.90 **Benefit:** 75% = $54.70 85% = $62.00
	TOE, treatment of dislocation of, by open reduction (Anaes.)
47072	**Fee:** $96.95 **Benefit:** 75% = $72.75 85% = $82.45
	TREATMENT OF FRACTURES
	Phalanx, middle or proximal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provided on the same occasion as a service described in item 47304, 47307, 47310, 47313, 47316 or 47319 (Anaes.) (See para TN.8.124 of explanatory notes to this Category)
47301	**Fee:** $89.50 **Benefit:** 75% = $67.15 85% = $76.10
	Metacarpal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provided on the same occasion as a service described in item 47301, 47307, 47310, 47313, 47316 or 47319 (Anaes.) (See para TN.8.124 of explanatory notes to this Category)
47304	**Fee:** $102.00 **Benefit:** 75% = $76.50
	Phalanx or metacarpal, treatment of fracture of, by closed reduction with percutaneous K wire fixation (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category)
47307	**Fee:** $206.25 **Benefit:** 75% = $154.70

47310	Phalanx or metacarpal, treatment of fracture of, by open reduction with fixation (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $340.35 **Benefit:** 75% = $255.30
47313	Phalanx or metacarpal, treatment of intra articular fracture of, by closed reduction with percutaneous K wire fixation (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $330.00 **Benefit:** 75% = $247.50
47316	Phalanx or metacarpal, treatment of intra articular fracture of, by open reduction with fixation, not provided on the same occasion as a service to which item 47319 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $654.85 **Benefit:** 75% = $491.15
47319	Middle phalanx, proximal end, treatment of intra articular fracture of, by open reduction with fixation, not provided on the same occasion as a service to which item 47316 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $670.30 **Benefit:** 75% = $502.75
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.) **Fee:** $96.95 **Benefit:** 75% = $72.75 85% = $82.45
47351	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.) **Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (Anaes.) **Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $388.30 **Benefit:** 75% = $291.25 85% = $330.10
47361	Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, by cast immobilisation, other than a service associated with a service to which item 47362, 47364, 47367, 47370 or 47373 applies (See para TN.8.124 of explanatory notes to this Category) **Fee:** $135.95 **Benefit:** 75% = $102.00 85% = $115.60
47362	Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, 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:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
47364	Radius or ulna, distal end of, not involving joint surface, treatment of fracture of, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $288.75 **Benefit:** 75% = $216.60
47367	Radius, distal end of, treatment of fracture of, by closed reduction with percutaneous fixation, other than

	a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $230.60 **Benefit:** 75% = $172.95
47370	Radius, distal end of, treatment of intra articular fracture of, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $418.70 **Benefit:** 75% = $314.05
47373	Ulna, distal end of, treatment of intra articular fracture of, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $299.05 **Benefit:** 75% = $224.30
47378	RADIUS OR ULNA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (Anaes.) **Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60
47381	RADIUS OR ULNA, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $262.10 **Benefit:** 75% = $196.60
47384	RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $349.40 **Benefit:** 75% = $262.05
47385	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $300.85 **Benefit:** 75% = $225.65
47386	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Anaes.) (Assist.) **Fee:** $485.40 **Benefit:** 75% = $364.05
47387	RADIUS AND ULNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Anaes.) (Assist.) **Fee:** $281.45 **Benefit:** 75% = $211.10 85% = $239.25
47390	RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $422.35 **Benefit:** 75% = $316.80
47393	RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $563.05 **Benefit:** 75% = $422.30
47396	OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (Anaes.) **Fee:** $194.05 **Benefit:** 75% = $145.55 85% = $164.95
47399	OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.)

	Fee: $388.30 **Benefit:** 75% = $291.25
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.) **Fee:** $291.15 **Benefit:** 75% = $218.40 85% = $247.50
47405	RADIUS, treatment of fracture of head or neck of, closed reduction of (Anaes.) **Fee:** $194.05 **Benefit:** 75% = $145.55 85% = $164.95
47408	RADIUS, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision where performed (Anaes.) (Assist.) **Fee:** $388.30 **Benefit:** 75% = $291.25
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.) **Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90
47414	HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes.) **Fee:** $233.05 **Benefit:** 75% = $174.80 85% = $198.10
47417	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $534.00 **Benefit:** 75% = $400.50
47423	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.) **Fee:** $223.25 **Benefit:** 75% = $167.45 85% = $189.80
47426	HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $334.95 **Benefit:** 75% = $251.25
47429	HUMERUS, proximal, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $446.50 **Benefit:** 75% = $334.90
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $558.20 **Benefit:** 75% = $418.65
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $427.20 **Benefit:** 75% = $320.40 85% = $363.15
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $679.75 **Benefit:** 75% = $509.85
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by

	open reduction (Anaes.) (Assist.) **Fee:** $849.50 **Benefit:** 75% = $637.15
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.) **Fee:** $233.05 **Benefit:** 75% = $174.80 85% = $198.10
47447	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $349.40 **Benefit:** 75% = $262.05
47450	HUMERUS, shaft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) **Fee:** $466.10 **Benefit:** 75% = $349.60
47451	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.) **Fee:** $561.80 **Benefit:** 75% = $421.35
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.) **Fee:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05
47456	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $407.90 **Benefit:** 75% = $305.95
47459	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $543.75 **Benefit:** 75% = $407.85
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes.) **Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90
47465	CLAVICLE, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $233.05 **Benefit:** 75% = $174.80 85% = $198.10
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes.) **Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90
47467	STERNUM, treatment of fracture of, by open reduction (Anaes.) **Fee:** $233.05 **Benefit:** 75% = $174.80
47468	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $446.50 **Benefit:** 75% = $334.90 85% = $379.55
47471	RIBS (1 or more), treatment of fracture of - each attendance **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70
47474	PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum **Fee:** $194.05 **Benefit:** 75% = $145.55 85% = $164.95

47477	PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum **Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
47480	PELVIC RING, treatment of fracture of, requiring traction (Anaes.) (Assist.) **Fee:** $485.40 **Benefit:** 75% = $364.05
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.) **Fee:** $582.50 **Benefit:** 75% = $436.90
47486	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Anaes.) (Assist.) **Fee:** $970.85 **Benefit:** 75% = $728.15
47489	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Anaes.) (Assist.) **Fee:** $1,456.30 **Benefit:** 75% = $1092.25
47492	ACETABULUM, treatment of fracture of, and associated dislocation of hip (Anaes.) **Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
47495	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.) **Fee:** $485.40 **Benefit:** 75% = $364.05 85% = $412.60
47498	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes.) (Assist.) **Fee:** $728.10 **Benefit:** 75% = $546.10
47501	ACETABULUM, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $970.85 **Benefit:** 75% = $728.15
47504	ACETABULUM, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,456.30 **Benefit:** 75% = $1092.25 85% = $1371.60
47507	ACETABULUM, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,456.30 **Benefit:** 75% = $1092.25
47510	ACETABULUM, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,456.30 **Benefit:** 75% = $1092.25
47513	SACRO-ILIAC JOINT DISRUPTION, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Anaes.) (Assist.)

	Fee: $388.30 **Benefit:** 75% = $291.25
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) **Fee:** $446.50 **Benefit:** 75% = $334.90 85% = $379.55
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.) **Fee:** $893.25 **Benefit:** 75% = $669.95
47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.) **Fee:** $776.80 **Benefit:** 75% = $582.60
47525	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.) **Fee:** $893.25 **Benefit:** 75% = $669.95
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) **Fee:** $776.80 **Benefit:** 75% = $582.60
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.) **Fee:** $990.25 **Benefit:** 75% = $742.70
47534	FEMUR, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Anaes.) (Assist.) **Fee:** $1,116.50 **Benefit:** 75% = $837.40
47537	FEMUR, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Anaes.) (Assist.) **Fee:** $446.50 **Benefit:** 75% = $334.90 85% = $379.55
47540	HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (Anaes.) **Fee:** $223.25 **Benefit:** 75% = $167.45 85% = $189.80
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.) **Fee:** $233.05 **Benefit:** 75% = $174.80 85% = $198.10
47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.) **Fee:** $349.40 **Benefit:** 75% = $262.05 85% = $297.00
47549	TIBIA, plateau of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $466.10 **Benefit:** 75% = $349.60
47552	TIBIA, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Anaes.) (Assist.) **Fee:** $388.30 **Benefit:** 75% = $291.25 85% = $330.10
47555	TIBIA, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.) **Fee:** $582.50 **Benefit:** 75% = $436.90

47558	TIBIA, plateau of, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.) **Fee:** $776.80 **Benefit:** 75% = $582.60
47561	TIBIA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564, 47567, 47570 or 47573 applies (Anaes.) **Fee:** $281.45 **Benefit:** 75% = $211.10 85% = $239.25
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) **Fee:** $422.35 **Benefit:** 75% = $316.80 85% = $359.00
47565	TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) **Fee:** $734.65 **Benefit:** 75% = $551.00
47566	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.) **Fee:** $936.45 **Benefit:** 75% = $702.35
47567	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $490.20 **Benefit:** 75% = $367.65 85% = $416.70
47570	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $563.05 **Benefit:** 75% = $422.30 85% = $478.60
47573	TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (Anaes.) (Assist.) **Fee:** $703.85 **Benefit:** 75% = $527.90
47576	FIBULA, treatment of fracture of (Anaes.) **Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.) **Fee:** $165.05 **Benefit:** 75% = $123.80 85% = $140.30
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.) (Assist.) **Fee:** $339.85 **Benefit:** 75% = $254.90
47585	PATELLA, treatment of fracture of, by internal fixation (Anaes.) (Assist.) **Fee:** $437.00 **Benefit:** 75% = $327.75
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 1 or more ligaments (Anaes.) (Assist.) **Fee:** $1,359.00 **Benefit:** 75% = $1019.25
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 1 or more ligaments (Anaes.) (Assist.)

	Fee: $1,650.65 **Benefit:** 75% = $1238.00
47594	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes.) **Fee:** $223.25 **Benefit:** 75% = $167.45 85% = $189.80
47597	ANKLE JOINT, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $334.95 **Benefit:** 75% = $251.25 85% = $284.75
47600	ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) **Fee:** $446.50 **Benefit:** 75% = $334.90
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) **Fee:** $582.50 **Benefit:** 75% = $436.90
47606	CALCANEUM OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (Anaes.) **Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $364.10 **Benefit:** 75% = $273.10 85% = $309.50
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $422.35 **Benefit:** 75% = $316.80 85% = $359.00
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $485.40 **Benefit:** 75% = $364.05 85% = $412.60
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $606.80 **Benefit:** 75% = $455.10
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $422.35 **Benefit:** 75% = $316.80 85% = $359.00
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $582.50 **Benefit:** 75% = $436.90
47627	TARSUS (excluding calcaneum or talus), treatment of fracture of (Anaes.) **Fee:** $165.05 **Benefit:** 75% = $123.80 85% = $140.30
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $349.40 **Benefit:** 75% = $262.05 85% = $297.00

47633	METATARSAL, 1 of, treatment of fracture of (Anaes.) **Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90
47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60
47639	METATARSAL, 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $233.05 **Benefit:** 75% = $174.80 85% = $198.10
47642	METATARSALS, 2 of, treatment of fracture of (Anaes.) **Fee:** $155.45 **Benefit:** 75% = $116.60 85% = $132.15
47645	METATARSALS, 2 of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $233.05 **Benefit:** 75% = $174.80 85% = $198.10
47648	METATARSALS, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $310.45 **Benefit:** 75% = $232.85
47651	METATARSALS, 3 or more of, treatment of fracture of (Anaes.) **Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.) **Fee:** $364.10 **Benefit:** 75% = $273.10 85% = $309.50
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $485.40 **Benefit:** 75% = $364.05
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $145.65 **Benefit:** 75% = $109.25 85% = $123.85
47666	PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (Anaes.) **Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
47672	PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90
47678	PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60
47726	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.) **Fee:** $145.65 **Benefit:** 75% = $109.25
47729	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.) **Fee:** $242.85 **Benefit:** 75% = $182.15
47732	VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service

	(Anaes.) (Assist.) **Fee:** $388.30 **Benefit:** 75% = $291.25
47735	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance **Fee:** $44.40 **Benefit:** 75% = $33.30 85% = $37.75
47738	NASAL BONES, treatment of fracture of, by reduction (Anaes.) **Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
47741	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.) **Fee:** $495.35 **Benefit:** 75% = $371.55
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) **Fee:** $419.35 **Benefit:** 75% = $314.55
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) **Fee:** $419.35 **Benefit:** 75% = $314.55
47762	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) **Fee:** $246.25 **Benefit:** 75% = $184.70 85% = $209.35
47765	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) **Fee:** $404.35 **Benefit:** 75% = $303.30
47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) **Fee:** $495.35 **Benefit:** 75% = $371.55
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) **Fee:** $569.10 **Benefit:** 75% = $426.85
47774	MAXILLA, treatment of fracture of, requiring open operation (Anaes.) (Assist.) **Fee:** $449.25 **Benefit:** 75% = $336.95
47777	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) **Fee:** $449.25 **Benefit:** 75% = $336.95
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) **Fee:** $584.05 **Benefit:** 75% = $438.05
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) **Fee:** $584.05 **Benefit:** 75% = $438.05 85% = $499.35

	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)
47786	**Fee:** $741.20 **Benefit:** 75% = $555.90
	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)
47789	**Fee:** $741.20 **Benefit:** 75% = $555.90
	GENERAL OPERATIONS
	BONE CYST, injection into or aspiration of (Anaes.)
47900	**Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60
	EPICONDYLITIS, open operation for (Anaes.)
47903	**Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.)
47904	**Fee:** $58.25 **Benefit:** 75% = $43.70 85% = $49.55
	DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital (Anaes.)
47906	**Fee:** $116.35 **Benefit:** 75% = $87.30
	PULP SPACE INFECTION, PARONYCHIA of FOOT, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category)
47912	**Fee:** $58.25 **Benefit:** 75% = $43.70 85% = $49.55
	INGROWING NAIL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)
47915	**Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60
	INGROWING NAIL OF TOE, partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.)
47916	**Fee:** $87.80 **Benefit:** 75% = $65.85 85% = $74.65
	INGROWING TOENAIL, radical excision of nailbed (Anaes.)
47918	**Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.)
47920	**Fee:** $392.70 **Benefit:** 75% = $294.55
	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.)
47921	**Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90
	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone (Anaes.)
47924	**Fee:** $38.80 **Benefit:** 75% = $29.10 85% = $33.00
47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes,

	removal of, in the operating theatre of a hospital - per bone (Anaes.) **Fee:** $145.65 **Benefit:** 75% = $109.25
47930	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.) (Assist.) **Fee:** $271.80 **Benefit:** 75% = $203.85
47933	SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision of, or simple removal of bunion and any associated bursa, not being a service associated with a service for removal of bursa (Anaes.) (See para TN.8.112 of explanatory notes to this Category) **Fee:** $213.45 **Benefit:** 75% = $160.10 85% = $181.45
47936	LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Anaes.) (Assist.) (See para TN.8.112 of explanatory notes to this Category) **Fee:** $262.10 **Benefit:** 75% = $196.60
47948	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $165.05 **Benefit:** 75% = $123.80
47951	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) **Fee:** $194.05 **Benefit:** 75% = $145.55 85% = $164.95
47954	TENDON, repair of, as an independent procedure (Anaes.) (Assist.) **Fee:** $388.30 **Benefit:** 75% = $291.25 85% = $330.10
47957	TENDON, large, lengthening of, as an independent procedure (Anaes.) (Assist.) **Fee:** $291.15 **Benefit:** 75% = $218.40
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) **Fee:** $135.95 **Benefit:** 75% = $102.00 85% = $115.60
47963	TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.) **Fee:** $223.25 **Benefit:** 75% = $167.45 85% = $189.80
47966	TENDON OR LIGAMENT, TRANSFER, as an independent procedure (Anaes.) (Assist.) **Fee:** $446.50 **Benefit:** 75% = $334.90
47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $271.80 **Benefit:** 75% = $203.85
47972	TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.) **Fee:** $217.15 **Benefit:** 75% = $162.90

	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.)
47975	**Fee:** $380.70 **Benefit:** 75% = $285.55
	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.)
47978	**Fee:** $231.20 **Benefit:** 75% = $173.40
	FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (Anaes.)
47981	**Fee:** $155.25 **Benefit:** 75% = $116.45 85% = $132.00
	FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.)
47982	**Fee:** $376.30 **Benefit:** 75% = $282.25
	BONE GRAFTS
	FEMUR, bone graft to (Anaes.) (Assist.)
48200	**Fee:** $776.80 **Benefit:** 75% = $582.60
	FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.)
48203	**Fee:** $941.75 **Benefit:** 75% = $706.35
	TIBIA, bone graft to (Anaes.) (Assist.)
48206	**Fee:** $583.10 **Benefit:** 75% = $437.35
	TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.)
48209	**Fee:** $747.60 **Benefit:** 75% = $560.70
	HUMERUS, bone graft to (Anaes.) (Assist.)
48212	**Fee:** $583.10 **Benefit:** 75% = $437.35
	HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.)
48215	**Fee:** $747.60 **Benefit:** 75% = $560.70
	RADIUS AND ULNA, bone graft to (Anaes.) (Assist.)
48218	**Fee:** $583.10 **Benefit:** 75% = $437.35
	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)
48221	**Fee:** $776.80 **Benefit:** 75% = $582.60
	RADIUS OR ULNA, bone graft to (Anaes.) (Assist.)
48224	**Fee:** $388.30 **Benefit:** 75% = $291.25
	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)
48227	**Fee:** $504.85 **Benefit:** 75% = $378.65
	SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.)
48230	**Fee:** $437.00 **Benefit:** 75% = $327.75

	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.)
48233	**Fee:** $631.05 **Benefit:** 75% = $473.30
	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.) (Assist.)
48236	**Fee:** $825.20 **Benefit:** 75% = $618.90
	BONE GRAFT, not being a service to which another item in this Group applies (Anaes.) (Assist.)
48239	**Fee:** $456.30 **Benefit:** 75% = $342.25
	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.)
48242	**Fee:** $631.05 **Benefit:** 75% = $473.30
	OSTEOTOMY AND OSTEECTOMY
	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies, any of items 49848, 49851, 47933 or 47936 apply (Anaes.) (Assist.)
48400	**Fee:** $339.85 **Benefit:** 75% = $254.90
	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)
48403	**Fee:** $534.00 **Benefit:** 75% = $400.50
	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)
48406	**Fee:** $339.85 **Benefit:** 75% = $254.90
	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)
48409	**Fee:** $534.00 **Benefit:** 75% = $400.50
	HUMERUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)
48412	**Fee:** $650.35 **Benefit:** 75% = $487.80
	HUMERUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)
48415	**Fee:** $825.20 **Benefit:** 75% = $618.90
	TIBIA, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)
48418	**Fee:** $650.35 **Benefit:** 75% = $487.80
	TIBIA, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)
48421	**Fee:** $825.20 **Benefit:** 75% = $618.90

	Femur or pelvis, osteotomy or osteectomy of, other than a service associated with surgery for femoroacetabular impingement, or to which item 47933 or 47936 applies (H) (Anaes.) (Assist.) (See para TN.8.127 of explanatory notes to this Category)
48424	**Fee:** $776.80 **Benefit:** 75% = $582.60
	FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)
48427	**Fee:** $941.75 **Benefit:** 75% = $706.35
	EPIPHYSEODESIS
	FEMUR, epiphysiodesis of (Anaes.) (Assist.)
48500	**Fee:** $339.85 **Benefit:** 75% = $254.90
	TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)
48503	**Fee:** $339.85 **Benefit:** 75% = $254.90
	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)
48506	**Fee:** $504.85 **Benefit:** 75% = $378.65
	EPIPHYSIODESIS, staple arrest of hemiepiphysis (Anaes.)
48509	**Fee:** $242.85 **Benefit:** 75% = $182.15
	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.)
48512	**Fee:** $922.35 **Benefit:** 75% = $691.80
	SHOULDER
	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.)
48900	**Fee:** $291.15 **Benefit:** 75% = $218.40 85% = $247.50
	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.) (Assist.)
48903	**Fee:** $582.50 **Benefit:** 75% = $436.90
	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Anaes.) (Assist.)
48906	**Fee:** $582.50 **Benefit:** 75% = $436.90
	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Anaes.) (Assist.)
48909	**Fee:** $776.80 **Benefit:** 75% = $582.60
	SHOULDER, arthrotomy of (Anaes.) (Assist.)
48912	**Fee:** $339.85 **Benefit:** 75% = $254.90 85% = $288.90
	SHOULDER, hemi-arthroplasty of (Anaes.) (Assist.)
48915	**Fee:** $776.80 **Benefit:** 75% = $582.60

	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.) (Assist.)
48918	**Fee:** $1,553.50 **Benefit:** 75% = $1165.15
	SHOULDER, total replacement arthroplasty, revision of (Anaes.) (Assist.)
48921	**Fee:** $1,601.90 **Benefit:** 75% = $1201.45
	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.) (Assist.)
48924	**Fee:** $1,844.70 **Benefit:** 75% = $1383.55
	SHOULDER prosthesis, removal of (Anaes.) (Assist.)
48927	**Fee:** $378.50 **Benefit:** 75% = $283.90
	SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.)
48930	**Fee:** $776.80 **Benefit:** 75% = $582.60
	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.)
48933	**Fee:** $1,019.40 **Benefit:** 75% = $764.55
	SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.)
48936	**Fee:** $776.80 **Benefit:** 75% = $582.60
	SHOULDER, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)
48939	**Fee:** $1,116.50 **Benefit:** 75% = $837.40
	SHOULDER, arthrodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone grafting or internal fixation (Anaes.) (Assist.)
48942	**Fee:** $1,456.30 **Benefit:** 75% = $1092.25
	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)
48945	**Fee:** $281.45 **Benefit:** 75% = $211.10
	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 (Anaes.) (Assist.)
48948	**Fee:** $631.05 **Benefit:** 75% = $473.30
	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)
48951	**Fee:** $922.35 **Benefit:** 75% = $691.80
	SHOULDER, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)
48954	**Fee:** $970.85 **Benefit:** 75% = $728.15
48957	SHOULDER, arthroscopic stabilisation of, for recurrent instability including labral repair or

	reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $1,116.50 **Benefit:** 75% = $837.40
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 (Anaes.) (Assist.) **Fee:** $970.85 **Benefit:** 75% = $728.15
	ELBOW
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.) (Assist.) **Fee:** $339.85 **Benefit:** 75% = $254.90
49103	ELBOW, ligamentous stabilisation of (Anaes.) (Assist.) **Fee:** $728.10 **Benefit:** 75% = $546.10
49106	ELBOW, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $970.85 **Benefit:** 75% = $728.15 85% = $886.15
49109	ELBOW, total synovectomy of (Anaes.) (Assist.) **Fee:** $728.10 **Benefit:** 75% = $546.10
49112	ELBOW, silastic or other replacement of radial head (Anaes.) (Assist.) **Fee:** $728.10 **Benefit:** 75% = $546.10
49115	ELBOW, total joint replacement of (Anaes.) (Assist.) **Fee:** $1,164.90 **Benefit:** 75% = $873.70
49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,537.70 **Benefit:** 75% = $1153.30
49117	ELBOW, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,845.25 **Benefit:** 75% = $1383.95
49118	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.) **Fee:** $281.45 **Benefit:** 75% = $211.10
49121	ELBOW, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.) **Fee:** $631.05 **Benefit:** 75% = $473.30
	WRIST
49200	WRIST, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation

	of the radiocarpal joint (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $844.55 **Benefit:** 75% = $633.45
49203	WRIST, limited arthrodesis of the intercarpal joint, with synovectomy if performed, with or without bone graft (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $631.05 **Benefit:** 75% = $473.30
49206	WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $582.50 **Benefit:** 75% = $436.90
49209	WRIST, total replacement arthroplasty of (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $776.80 **Benefit:** 75% = $582.60
49210	WRIST, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,025.35 **Benefit:** 75% = $769.05
49211	WRIST, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,230.45 **Benefit:** 75% = $922.85
49212	WRIST, arthrotomy of (Anaes.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $242.85 **Benefit:** 75% = $182.15
49215	WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $670.00 **Benefit:** 75% = $502.50
49218	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $281.45 **Benefit:** 75% = $211.10
49221	WRIST, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $631.05 **Benefit:** 75% = $473.30
49224	WRIST, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy, not being a service associated with any other arthroscopic procedure of the wrist (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $728.10 **Benefit:** 75% = $546.10

49227	WRIST, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $728.10 **Benefit:** 75% = $546.10
	HIP
49300	SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.) **Fee:** $537.55 **Benefit:** 75% = $403.20
49303	Hip, arthrotomy of, including lavage, drainage or biopsy when performed, other than a service associated with surgery for femoroacetabular impingement (H) (Anaes.) (Assist.) (See para TN.8.127 of explanatory notes to this Category) **Fee:** $563.05 **Benefit:** 75% = $422.30
49306	HIP arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $1,116.50 **Benefit:** 75% = $837.40
49309	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Anaes.) (Assist.) **Fee:** $776.80 **Benefit:** 75% = $582.60
49312	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.) (Assist.) **Fee:** $970.85 **Benefit:** 75% = $728.15
49315	HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist.) **Fee:** $873.80 **Benefit:** 75% = $655.35
49318	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.) (Assist.) **Fee:** $1,359.00 **Benefit:** 75% = $1019.25
49319	HIP, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) **Fee:** $2,387.65 **Benefit:** 75% = $1790.75
49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,650.65 **Benefit:** 75% = $1238.00
49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,941.80 **Benefit:** 75% = $1456.35
49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,233.00 **Benefit:** 75% = $1674.75
49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.)

	Fee: $2,233.00 **Benefit:** 75% = $1674.75
49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,524.30 **Benefit:** 75% = $1893.25
49336	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes.) (Assist.) **Fee:** $368.85 **Benefit:** 75% = $276.65
49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.) (Assist.) **Fee:** $2,864.10 **Benefit:** 75% = $2148.10
49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.) **Fee:** $2,864.10 **Benefit:** 75% = $2148.10
49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.) **Fee:** $3,398.00 **Benefit:** 75% = $2548.50
49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.) **Fee:** $873.80 **Benefit:** 75% = $655.35
49360	HIP, diagnostic arthroscopy of, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.) **Fee:** $354.70 **Benefit:** 75% = $266.05
49363	HIP, diagnostic arthroscopy of, with synovial biopsy, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.) **Fee:** $427.15 **Benefit:** 75% = $320.40 85% = $363.10
49366	Hip, arthroscopic surgery of, other than a service associated with another arthroscopic procedure of the hip, or a service associated with surgery for femoroacetabular impingement (H) (Anaes.) (Assist.) (See para TN.8.127 of explanatory notes to this Category) **Fee:** $631.05 **Benefit:** 75% = $473.30
	KNEE
49500	KNEE, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Anaes.) (Assist.) **Fee:** $388.30 **Benefit:** 75% = $291.25
49503	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) - any 1 procedure (Anaes.) (Assist.) **Fee:** $504.85 **Benefit:** 75% = $378.65
49506	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not

	being a service to which another item in this Group applies) - any 2 or more procedures (Anaes.) (Assist.) **Fee:** $757.35 **Benefit:** 75% = $568.05
49509	KNEE, total synovectomy or arthrodesis with synovectomy if performed (Anaes.) (Assist.) **Fee:** $776.80 **Benefit:** 75% = $582.60
49512	KNEE, arthrodesis of, with synovectomy if performed, with removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,116.50 **Benefit:** 75% = $837.40
49515	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.) (Assist.) **Fee:** $873.80 **Benefit:** 75% = $655.35
49517	KNEE, hemiarthroplasty of (Anaes.) (Assist.) **Fee:** $1,244.05 **Benefit:** 75% = $933.05
49518	KNEE, total replacement arthroplasty of (Anaes.) (Assist.) **Fee:** $1,359.00 **Benefit:** 75% = $1019.25
49519	KNEE, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) **Fee:** $2,387.65 **Benefit:** 75% = $1790.75
49521	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,650.65 **Benefit:** 75% = $1238.00
49524	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,941.80 **Benefit:** 75% = $1456.35
49527	KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,650.65 **Benefit:** 75% = $1238.00
49530	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) **Fee:** $2,039.00 **Benefit:** 75% = $1529.25
49533	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) **Fee:** $2,330.25 **Benefit:** 75% = $1747.70
49534	KNEE, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.) **Fee:** $463.60 **Benefit:** 75% = $347.70
49536	KNEE, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)

	Fee: $970.85 **Benefit:** 75% = $728.15
	KNEE, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service to which another item in this Group applies or a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)
49539	**Fee:** $970.85 **Benefit:** 75% = $728.15
	KNEE, reconstructive surgery to cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)
49542	**Fee:** $1,359.00 **Benefit:** 75% = $1019.25
	KNEE, revision arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)
49545	**Fee:** $776.80 **Benefit:** 75% = $582.60
	KNEE, revision of patello-femoral stabilisation (Anaes.) (Assist.)
49548	**Fee:** $970.85 **Benefit:** 75% = $728.15
	KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.)
49551	**Fee:** $1,359.00 **Benefit:** 75% = $1019.25
	KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.) (Assist.)
49554	**Fee:** $1,941.80 **Benefit:** 75% = $1456.35
	KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation or any other arthroscopic procedure of the knee region (Anaes.) (Assist.) (See para TN.8.117 of explanatory notes to this Category)
49557	**Fee:** $281.45 **Benefit:** 75% = $211.10
	KNEE, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)
49558	**Fee:** $281.45 **Benefit:** 75% = $211.10
	KNEE, arthroscopic surgery of, involving chondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)
49559	**Fee:** $421.50 **Benefit:** 75% = $316.15
	KNEE, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release - not being a service associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)
49560	**Fee:** $568.85 **Benefit:** 75% = $426.65
	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)
49561	**Fee:** $695.05 **Benefit:** 75% = $521.30

	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)
49562	**Fee:** $758.45 **Benefit:** 75% = $568.85
	KNEE, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft (excluding autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation) -not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) (See para TN.8.117 of explanatory notes to this Category)
49563	**Fee:** $821.60 **Benefit:** 75% = $616.20
	KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)
49564	**Fee:** $947.75 **Benefit:** 75% = $710.85
	KNEE, arthroscopic total synovectomy of, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)
49566	**Fee:** $776.80 **Benefit:** 75% = $582.60
	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.) (Assist.)
49569	**Fee:** $776.80 **Benefit:** 75% = $582.60
	ANKLE
	ANKLE, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.)
49700	**Fee:** $281.45 **Benefit:** 75% = $211.10
	ANKLE, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.)
49703	**Fee:** $631.05 **Benefit:** 75% = $473.30
	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.)
49706	**Fee:** $339.85 **Benefit:** 75% = $254.90
	ANKLE, ligamentous stabilisation of (Anaes.) (Assist.)
49709	**Fee:** $728.10 **Benefit:** 75% = $546.10
	ANKLE, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)
49712	**Fee:** $776.80 **Benefit:** 75% = $582.60
	ANKLE, total joint replacement of (Anaes.) (Assist.)
49715	**Fee:** $1,164.90 **Benefit:** 75% = $873.70
	ANKLE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.)
49716	**Fee:** $1,537.70 **Benefit:** 75% = $1153.30

49717	ANKLE, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,845.25 **Benefit:** 75% = $1383.95
49718	ANKLE, Achilles' tendon or other major tendon, repair of (Anaes.) (Assist.) **Fee:** $388.30 **Benefit:** 75% = $291.25
49721	ANKLE, Achilles' tendon rupture managed by non-operative treatment **Fee:** $242.85 **Benefit:** 75% = $182.15 85% = $206.45
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes.) (Assist.) **Fee:** $679.75 **Benefit:** 75% = $509.85
49727	ANKLE, Achilles' tendon, operation for lengthening (Anaes.) (Assist.) **Fee:** $291.15 **Benefit:** 75% = $218.40
49728	ANKLE, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Anaes.) (Assist.) **Fee:** $582.35 **Benefit:** 75% = $436.80
	FOOT
49800	FOOT, flexor or extensor tendon, primary repair of (Anaes.) **Fee:** $135.95 **Benefit:** 75% = $102.00 85% = $115.60
49803	FOOT, flexor or extensor tendon, secondary repair of (Anaes.) **Fee:** $174.80 **Benefit:** 75% = $131.10 85% = $148.60
49806	FOOT, subcutaneous tenotomy of, 1 or more tendons (Anaes.) **Fee:** $135.95 **Benefit:** 75% = $102.00 85% = $115.60
49809	FOOT, open tenotomy of, with or without tenoplasty (Anaes.) **Fee:** $223.25 **Benefit:** 75% = $167.45
49812	FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $446.50 **Benefit:** 75% = $334.90
49815	FOOT, triple arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $776.80 **Benefit:** 75% = $582.60
49818	FOOT, excision of calcaneal spur (Anaes.) (Assist.) **Fee:** $281.45 **Benefit:** 75% = $211.10
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes.) (Assist.) **Fee:** $446.50 **Benefit:** 75% = $334.90
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes.) (Assist.)

	Fee: $781.65 **Benefit:** 75% = $586.25
49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.) **Fee:** $485.40 **Benefit:** 75% = $364.05
49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.) **Fee:** $849.50 **Benefit:** 75% = $637.15
49833	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.) **Fee:** $534.00 **Benefit:** 75% = $400.50
49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.) **Fee:** $922.35 **Benefit:** 75% = $691.80
49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.) **Fee:** $667.45 **Benefit:** 75% = $500.60
49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.) **Fee:** $1,152.70 **Benefit:** 75% = $864.55
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.) (Assist.) **Fee:** $534.00 **Benefit:** 75% = $400.50
49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.) (Assist.) **Fee:** $922.35 **Benefit:** 75% = $691.80
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $485.40 **Benefit:** 75% = $364.05
49848	FOOT, correction of claw or hammer toe (Anaes.) **Fee:** $165.05 **Benefit:** 75% = $123.80 85% = $140.30
49851	FOOT, correction of claw or hammer toe with internal fixation (Anaes.) **Fee:** $213.45 **Benefit:** 75% = $160.10
49854	FOOT, radical plantar fasciotomy or fasciectomy of (Anaes.) (Assist.) **Fee:** $388.30 **Benefit:** 75% = $291.25
49857	FOOT, metatarso-phalangeal joint replacement (Anaes.) (Assist.) **Fee:** $359.20 **Benefit:** 75% = $269.40

	FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.)
49860	**Fee:** $291.15 **Benefit:** 75% = $218.40
	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.)
49863	**Fee:** $437.00 **Benefit:** 75% = $327.75
	FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.)
49866	**Fee:** $310.45 **Benefit:** 75% = $232.85
	TALIPES EQUINOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or manipulation - each attendance (Anaes.)
49878	**Fee:** $58.25 **Benefit:** 75% = $43.70 85% = $49.55
	OTHER JOINTS
	JOINT, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Anaes.) (Assist.)
50100	**Fee:** $281.45 **Benefit:** 75% = $211.10 85% = $239.25
	JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.) (Assist.)
50102	**Fee:** $631.05 **Benefit:** 75% = $473.30
	JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.)
50103	**Fee:** $339.85 **Benefit:** 75% = $254.90
	JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.)
50104	**Fee:** $322.05 **Benefit:** 75% = $241.55 85% = $273.75
	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.)
50106	**Fee:** $485.40 **Benefit:** 75% = $364.05
	JOINT, arthrodesis of, not being a service to which another item in this Group applies, with synovectomy if performed (Anaes.) (Assist.)
50109	**Fee:** $485.40 **Benefit:** 75% = $364.05
	CICATRICIAL FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Anaes.) (Assist.)
50112	**Fee:** $372.35 **Benefit:** 75% = $279.30
	JOINT or JOINTS, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (Anaes.)
50115	**Fee:** $147.45 **Benefit:** 75% = $110.60
	SUBTALAR JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)
50118	**Fee:** $446.50 **Benefit:** 75% = $334.90

	GREATER TROCHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.)
50121	**Fee:** $873.80 **Benefit:** 75% = $655.35
	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes.) (Assist.)
50127	**Fee:** $724.45 **Benefit:** 75% = $543.35
	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)
50130	**Fee:** $322.05 **Benefit:** 75% = $241.55
	MALIGNANT DISEASE
	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.)
50200	**Fee:** $194.05 **Benefit:** 75% = $145.55 85% = $164.95
	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, involving neurovascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.)
50201	**Fee:** $339.75 **Benefit:** 75% = $254.85
	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.)
50203	**Fee:** $427.20 **Benefit:** 75% = $320.40 85% = $363.15
	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.)
50206	**Fee:** $631.05 **Benefit:** 75% = $473.30
	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.)
50209	**Fee:** $776.80 **Benefit:** 75% = $582.60
	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.) (Assist.)
50212	**Fee:** $1,699.00 **Benefit:** 75% = $1274.25
	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Anaes.) (Assist.)
50215	**Fee:** $2,135.90 **Benefit:** 75% = $1601.95
	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint, with synovectomy if performed (Anaes.) (Assist.)
50218	**Fee:** $2,815.60 **Benefit:** 75% = $2111.70
	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes.) (Assist.)
50221	**Fee:** $2,621.25 **Benefit:** 75% = $1965.95

	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Anaes.) (Assist.)
50224	**Fee:** $2,912.60 **Benefit:** 75% = $2184.45 85% = $2827.90
	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.) (Assist.)
50227	**Fee:** $3,398.00 **Benefit:** 75% = $2548.50
	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.) (Assist.)
50230	**Fee:** $1,747.55 **Benefit:** 75% = $1310.70
	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.)
50233	**Fee:** $2,233.00 **Benefit:** 75% = $1674.75
	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.) (Assist.)
50236	**Fee:** $1,747.55 **Benefit:** 75% = $1310.70
	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes.) (Assist.)
50239	**Fee:** $1,164.90 **Benefit:** 75% = $873.70
	LIMB LENGTHENING AND DEFORMITY CORRECTION
	JOINT DEFORMITY, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes.) (Assist.)
50300	**Fee:** $1,193.85 **Benefit:** 75% = $895.40
	LIMB LENGTHENING, 5cm or less, by gradual distraction, with application of an external fixator or intra-medullary device, in the operating theatre of a hospital - payable only once per limb in any 12 month period (Anaes.) (Assist.)
50303	**Fee:** $1,630.00 **Benefit:** 75% = $1222.50
	LIMB LENGTHENING , where the lengthening is bipolar, or bone transport is performed or where the fixator is extended to correct an adjacent joint deformity, or where the lengthening is greater than 5cm (Anaes.) (Assist.)
50306	**Fee:** $2,545.00 **Benefit:** 75% = $1908.75 85% = $2460.30
	RING FIXATOR OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50303 or 50306 applies (Anaes.) (Assist.)
50309	**Fee:** $314.60 **Benefit:** 75% = $235.95
	ANKLE, synovectomy of, by arthroscopic or open means - not associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.)
50312	**Fee:** $721.95 **Benefit:** 75% = $541.50
	TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.)
50315	**Fee:** $714.95 **Benefit:** 75% = $536.25

	TALIPES EQUINOVARUS, medial release of (Anaes.) (Assist.)
50318	**Fee:** $714.95 **Benefit:** 75% = $536.25
	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.)
50321	**Fee:** $957.85 **Benefit:** 75% = $718.40
	TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.)
50324	**Fee:** $1,365.55 **Benefit:** 75% = $1024.20
	TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist.)
50327	**Fee:** $1,665.60 **Benefit:** 75% = $1249.20
	TALIPES EQUINOVARUS, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes.)
50330	**Fee:** $235.85 **Benefit:** 75% = $176.90
	TARSAL COALITION, excision of, with interposition of muscle, fat graft or similar graft (Anaes.) (Assist.)
50333	**Fee:** $636.10 **Benefit:** 75% = $477.10
	TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.) (Assist.)
50336	**Fee:** $950.85 **Benefit:** 75% = $713.15
	FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.) (Assist.)
50339	**Fee:** $579.10 **Benefit:** 75% = $434.35
	FOOT AND ANKLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes.) (Assist.)
50342	**Fee:** $672.00 **Benefit:** 75% = $504.00
	HYPEREXTENSION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes.) (Assist.)
50345	**Fee:** $357.50 **Benefit:** 75% = $268.15
	HIP, KNEE AND LEG PROCEDURES KNEE, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital (Anaes.)
50348	**Fee:** $235.85 **Benefit:** 75% = $176.90
	HIP, congenital dislocation of, treatment of, by closed reduction (Anaes.)
50349	**Fee:** $330.15 **Benefit:** 75% = $247.65 85% = $280.65
	HIP, developmental dislocation of, open reduction of (Anaes.) (Assist.)
50351	**Fee:** $1,647.15 **Benefit:** 75% = $1235.40

	HIP, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.)
50352	**Fee:** $58.25 **Benefit:** 75% = $43.70 85% = $49.55
	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes.) (Assist.)
50353	**Fee:** $365.90 **Benefit:** 75% = $274.45
	TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.)
50354	**Fee:** $1,351.05 **Benefit:** 75% = $1013.30 85% = $1266.35
	KNEE, LEG OR THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer (Anaes.) (Assist.)
50357	**Fee:** $579.10 **Benefit:** 75% = $434.35
	KNEE, LEG OR THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.)
50360	**Fee:** $672.00 **Benefit:** 75% = $504.00
	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Anaes.) (Assist.)
50363	**Fee:** $514.65 **Benefit:** 75% = $386.00
	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes.) (Assist.)
50366	**Fee:** $900.75 **Benefit:** 75% = $675.60
	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assist.)
50369	**Fee:** $672.00 **Benefit:** 75% = $504.00
	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (Anaes.) (Assist.)
50372	**Fee:** $1,179.55 **Benefit:** 75% = $884.70
	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Anaes.) (Assist.)
50375	**Fee:** $514.65 **Benefit:** 75% = $386.00
	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Anaes.) (Assist.)
50378	**Fee:** $900.75 **Benefit:** 75% = $675.60
	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Anaes.) (Assist.)
50381	**Fee:** $672.00 **Benefit:** 75% = $504.00
	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (Anaes.) (Assist.)
50384	**Fee:** $1,179.55 **Benefit:** 75% = $884.70
50387	HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater

	trochanter, or transfer of adductors to ischium (Anaes.) (Assist.) **Fee:** $672.00 **Benefit:** 75% = $504.00
50390	PERTHES, CEREBRAL PALSY, or other neuromuscular conditions, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital (Anaes.) **Fee:** $235.85 **Benefit:** 75% = $176.90
50393	PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.) **Fee:** $872.05 **Benefit:** 75% = $654.05
50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.) **Fee:** $2,864.10 **Benefit:** 75% = $2148.10
	SHOULDER, ARM AND FOREARM PROCEDURES
50396	HAND, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes.) (Assist.) **Fee:** $479.10 **Benefit:** 75% = $359.35
50399	FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes.) (Assist.) **Fee:** $950.85 **Benefit:** 75% = $713.15
50402	TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.) (Assist.) **Fee:** $436.15 **Benefit:** 75% = $327.15
50405	ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes.) (Assist.) **Fee:** $593.35 **Benefit:** 75% = $445.05
50408	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.) **Fee:** $1,029.40 **Benefit:** 75% = $772.05
50411	AMPUTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES 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:** $1,351.05 **Benefit:** 75% = $1013.30 85% = $1266.35
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:** $1,822.85 **Benefit:** 75% = $1367.15 85% = $1738.15
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:** $1,351.05 **Benefit:** 75% = $1013.30 85% = $1266.35
50420	PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.)

	Fee: $1,115.15 **Benefit:** 75% = $836.40
50423	TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.) **Fee:** $1,029.40 **Benefit:** 75% = $772.05 85% = $944.70
	TUMOROUS CONDITIONS
50426	DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes.) (Assist.) **Fee:** $479.10 **Benefit:** 75% = $359.35
	SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY
50450	UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of femoral torsion by rotational 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 (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,265.25 **Benefit:** 75% = $948.95
50451	UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of femoral torsion by rotational 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 (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,265.25 **Benefit:** 75% = $948.95
50455	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with

	diplegic cerebral palsy that comprises: (`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.  (`) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,432.80 **Benefit:** 75% = $1074.60
50456	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,432.80 **Benefit:** 75% = $1074.60
50460	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies. (`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.  (`) Correction of muscle imbalance by tendon transfer/transfers. (`) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,139.25 **Benefit:** 75% = $1604.45
50461	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,139.25 **Benefit:** 75% = $1604.45
50465	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and

	bilateral tibial osteotomies. (`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.  (`) Correction of muscle imbalance by tendon transfer/transfers. (`) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.  (`) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,013.10 **Benefit:** 75% = $2259.85
50466	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,013.10 **Benefit:** 75% = $2259.85
50470	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation. (`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.  (`) Correction of muscle imbalance by tendon transfer/transfers. (`) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.  (`) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. (`) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,821.30 **Benefit:** 75% = $2866.00
50471	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial

	osteotomies and bilateral foot stabilisation. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. (e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,821.30 **Benefit:** 75% = $2866.00
50475	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: (`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.  (`) Correction of muscle imbalance by tendon transfer/transfers. (`) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation.  (`) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. (`) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation.  (`) Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,409.40 **Benefit:** 75% = $3307.05
50476	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. (d) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. (e) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. (f) Correction of foot instability by os calcis lengthening or subtalar fusion.

	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,409.40 **Benefit:** 75% = $3307.05
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS
50500	RADIUS OR ULNA, distal end of, *with open growth plate*, treatment of fracture of, by closed reduction (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $285.30 **Benefit:** 75% = $214.00 85% = $242.55
50504	RADIUS OR ULNA, distal end of, *with open growth plate*, treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $380.55 **Benefit:** 75% = $285.45 85% = $323.50
50508	RADIUS, distal end of, *with open growth plate*, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $407.55 **Benefit:** 75% = $305.70 85% = $346.45
50512	RADIUS, distal end of, *with open growth plate*, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $543.80 **Benefit:** 75% = $407.85
50516	RADIUS OR ULNA, shaft of, *with open growth plate*, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $366.95 **Benefit:** 75% = $275.25
50520	RADIUS OR ULNA, shaft of, *with open growth plate*, treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $489.25 **Benefit:** 75% = $366.95
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 undertaken in the operating theatre of a hospital (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $421.30 **Benefit:** 75% = $316.00
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 (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $679.60 **Benefit:** 75% = $509.70
50532	RADIUS AND ULNA, shafts of, *with open growth plates*, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category)

	Fee: $591.30 **Benefit:** 75% = $443.50
50536	RADIUS AND ULNA, shafts of, *with open growth plates*, treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $788.30 **Benefit:** 75% = $591.25
50540	OLECRANON, *with open growth plate*, treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $543.80 **Benefit:** 75% = $407.85
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:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05
50548	RADIUS, *with open growth plate*, treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $543.80 **Benefit:** 75% = $407.85
50552	HUMERUS, proximal, *with open growth plate*, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $469.00 **Benefit:** 75% = $351.75
50556	HUMERUS, proximal, *with open growth plate*, treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $625.15 **Benefit:** 75% = $468.90
50560	HUMERUS, shaft of, *with open growth plate*, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $489.25 **Benefit:** 75% = $366.95
50564	HUMERUS, shaft of, *with open growth plate*, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $652.40 **Benefit:** 75% = $489.30
50568	HUMERUS, *with open growth plate*, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $570.90 **Benefit:** 75% = $428.20
50572	HUMERUS, *with open growth plate*, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $761.15 **Benefit:** 75% = $570.90
50576	FEMUR, *with open growth plate*, treatment of fracture of, by closed reduction or traction (Anaes.)

	(Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $625.15 **Benefit:** 75% = $468.90 85% = $540.45
50580	TIBIA, *with open growth plate*, plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $652.40 **Benefit:** 75% = $489.30
50584	TIBIA, distal, *with open growth plate*, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $625.15 **Benefit:** 75% = $468.90
50588	TIBIA AND FIBULA, *with open growth plates*, treatment of fracture of, by internal fixation (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $815.40 **Benefit:** 75% = $611.55
	SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS
50600	SCOLIOSIS OR KYPHOSIS, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $448.25 **Benefit:** 75% = $336.20
50604	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,902.65 **Benefit:** 75% = $1427.00
50608	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,534.05 **Benefit:** 75% = $2650.55
50612	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $5,026.80 **Benefit:** 75% = $3770.10
50616	SCOLIOSIS, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $638.70 **Benefit:** 75% = $479.05
50620	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery, involving more than 1 of osteotomy, fusion, removal of instrumentation or instrumentation, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,534.05 **Benefit:** 75% = $2650.55

50624	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,534.05 **Benefit:** 75% = $2650.55
50628	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,365.45 **Benefit:** 75% = $3274.10
50632	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,669.85 **Benefit:** 75% = $2752.40
50636	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, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,077.60 **Benefit:** 75% = $3058.20
50640	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,254.05 **Benefit:** 75% = $1690.55
50644	SPINE, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,174.85 **Benefit:** 75% = $1631.15
	TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS
50650	HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $427.70 **Benefit:** 75% = $320.80 85% = $363.55
50654	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica, including examination of the hip (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $512.15 **Benefit:** 75% = $384.15
50658	HIP DYSPLASIA or DISLOCATION, in a child, examination and manipulation of the hip under anaesthesia (Anaes.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $203.90 **Benefit:** 75% = $152.95 85% = $173.35

T8. SURGICAL OPERATIONS	16. RADIOFREQUENCY AND MICROWAVE TISSUE ABLATION
	Group T8. Surgical Operations
	Subgroup 16. Radiofrequency And Microwave Tissue Ablation
50950	Unresectable primary malignant tumour of the liver, destruction of, by percutaneous radiofrequency ablation or percutaneous microwave tissue ablation (including any associated imaging services), other than a service associated with a service to which item 30419 or 50952 applies (Anaes.) **Fee:** $842.60 **Benefit:** 75% = $631.95 85% = $757.90
50952	Unresectable primary malignant tumour of the liver, destruction of, by open or laparoscopic radiofrequency ablation or open or laparoscopic microwave tissue ablation (including any associated imaging services), if a multi-disciplinary team has assessed that percutaneous radiofrequency ablation or percutaneous microwave tissue ablation cannot be performed or is not practical because of one or more of the following clinical circumstances: (a) percutaneous access cannot be achieved; (b) vital organs or tissues are at risk of damage from the percutaneous radiofrequency ablation or percutaneous microwave tissue ablation procedure; (c) resection of one part of the liver is possible, however there is at least one primary liver tumour in an unresectable portion of the liver that is suitable for radiofrequency ablation or microwave tissue ablation; other than a service associated with a service to which item 30419 or 50950 applies. (Anaes.) (See para TN.8.120 of explanatory notes to this Category) **Fee:** $842.60 **Benefit:** 75% = $631.95 85% = $757.90

T8. SURGICAL OPERATIONS	17. SPINAL SURGERY
	Group T8. Surgical Operations
	Subgroup 17. Spinal Surgery
51011	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, one motion segment, not being a service associated with a service to which item 51012, 51013, 51014 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $1,480.35 **Benefit:** 75% = $1110.30
51012	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 2 motion segments, not being a service associated with a service to which item 51011, 51013, 51014 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $1,973.55 **Benefit:** 75% = $1480.20

51013	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 3 motion segments, not being a service associated with a service to which item 51011, 51012, 51014 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $2,467.00 **Benefit:** 75% = $1850.25
51014	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $2,960.40 **Benefit:** 75% = $2220.30
51015	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, more than 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51014 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $3,453.80 **Benefit:** 75% = $2590.35
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:** $789.35 **Benefit:** 75% = $592.05
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:** $1,321.25 **Benefit:** 75% = $990.95
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:** $1,643.50 **Benefit:** 75% = $1232.65
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:** $1,955.85 **Benefit:** 75% = $1466.90
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:** $2,258.00 **Benefit:** 75% = $1693.50
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:** $2,639.15 **Benefit:** 75% = $1979.40
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:** $2,889.45 **Benefit:** 75% = $2167.10
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:** $970.85 **Benefit:** 75% = $728.15
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:** $1,165.05 **Benefit:** 75% = $873.80
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:** $1,359.25 **Benefit:** 75% = $1019.45
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:** $1,456.30 **Benefit:** 75% = $1092.25
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:** $1,553.35 **Benefit:** 75% = $1165.05
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:** $1,650.50 **Benefit:** 75% = $1237.90
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:** $1,116.50 **Benefit:** 75% = $837.40
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:** $1,563.15 **Benefit:** 75% = $1172.40

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:** $1,953.95 **Benefit:** 75% = $1465.50
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:** $2,121.40 **Benefit:** 75% = $1591.05
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:** $2,233.05 **Benefit:** 75% = $1674.80
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:** $1,907.80 **Benefit:** 75% = $1430.85
51052	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.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,320.30 **Benefit:** 75% = $1740.25
51053	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.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,639.95 **Benefit:** 75% = $1980.00
51054	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.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $1,407.65 **Benefit:** 75% = $1055.75
51055	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.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category)

	Fee: $2,111.45 **Benefit:** 75% = $1583.60
51056	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.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,463.35 **Benefit:** 75% = $1847.55
51057	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.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,475.00 **Benefit:** 75% = $1856.25
51058	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.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,784.85 **Benefit:** 75% = $2088.65
51059	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.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $3,403.10 **Benefit:** 75% = $2552.35
51061	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.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $2,923.20 **Benefit:** 75% = $2192.40
51062	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.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $3,789.15 **Benefit:** 75% = $2841.90

51063	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.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $4,589.35 **Benefit:** 75% = $3442.05
51064	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.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $5,107.60 **Benefit:** 75% = $3830.70
51065	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.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $5,648.95 **Benefit:** 75% = $4236.75
51066	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.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $5,947.70 **Benefit:** 75% = $4460.80
51071	Removal of intradural lesion, not being a service associated with a service to which item 51072 or 51073 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,578.10 **Benefit:** 75% = $1933.60
51072	Craniocervical junction lesion, transoral approach for, not being a service associated with a service to which item 51071 or 51073 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,681.20 **Benefit:** 75% = $2010.90
51073	Removal of intramedullary tumour or arteriovenous malformation, not being a service associated with a service to which item 51071 or 51072 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $3,403.10 **Benefit:** 75% = $2552.35
51102	Thoracoplasty in combination with thoracic scoliosis correction—3 or more ribs (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $1,220.40 **Benefit:** 75% = $915.30
51103	Odontoid screw fixation (Anaes.) (Assist.) (See para TN.8.141, TN.8.148 of explanatory notes to this Category) **Fee:** $2,144.75 **Benefit:** 75% = $1608.60
51110	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.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $776.80 **Benefit:** 75% = $582.60 85% = $692.10

51111	Skull calipers or halo, insertion of, as an independent procedure (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $330.15 **Benefit:** 75% = $247.65
51112	Plaster jacket, application of, as an independent procedure (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $223.25 **Benefit:** 75% = $167.45 85% = $189.80
51113	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $247.55 **Benefit:** 75% = $185.70
51114	Halo thoracic orthosis—application of both halo and thoracic jacket (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $437.00 **Benefit:** 75% = $327.75
51115	Halo femoral traction, as an independent procedure (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $437.00 **Benefit:** 75% = $327.75 85% = $371.45
51120	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:** $242.85 **Benefit:** 75% = $182.15
51130	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:** $1,849.70 **Benefit:** 75% = $1387.30
51131	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:** $1,116.50 **Benefit:** 75% = $837.40
51140	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:** $456.30 **Benefit:** 75% = $342.25
51141	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:** $844.10 **Benefit:** 75% = $633.10
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:** $456.30 **Benefit:** 75% = $342.25
51150	Coccyx, excision of (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $459.35 **Benefit:** 75% = $344.55
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:** $1,185.95 **Benefit:** 75% = $889.50
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:** $1,495.30 **Benefit:** 75% = $1121.50
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:** $2,252.85 **Benefit:** 75% = $1689.65
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:** $946.10 **Benefit:** 75% = $709.60

T9. ASSISTANCE AT OPERATIONS

	Group T9. Assistance At Operations
51300	Assistance at any operation identified by the word "Assist." for which the fee does not exceed $575.75 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 $575.75

T9. ASSISTANCE AT OPERATIONS	
	(See para TN.9.2, TN.9.1 of explanatory notes to this Category) **Fee:** $89.00 **Benefit:** 75% = $66.75 85% = $75.65
51303	Assistance at any operation identified by the word "Assist." for which the fee exceeds $575.75 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds $575.75 (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
51306	Assistance at a birth involving Caesarean section (See para TN.9.1 of explanatory notes to this Category) **Fee:** $128.55 **Benefit:** 75% = $96.45 85% = $109.30
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
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:** $280.90 **Benefit:** 75% = $210.70 85% = $238.80
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:** $185.40 **Benefit:** 75% = $139.05 85% = $157.60

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
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20102	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20104	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20124	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20142	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70 **Extended Medicare Safety Net Cap:** $81.60
20143	INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20144	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
20145	INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
20146	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20147	INITIATION OF MANAGEMENT OF ANAESTHESIA for squint repair (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20148	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05

20162	Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal ablation (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
20164	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20172	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
20174	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units) **Fee:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10
20176	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20192	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
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:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
20212	INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20214	INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units) **Fee:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10
20216	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units) **Fee:** $408.00 **Benefit:** 75% = $306.00 85% = $346.80
20220	INITIATION OF MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic units)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	**1. HEAD**
	Fee: $204.00 **Benefit:** 75% = $153.00 85% = $173.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic units)
20222	**Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units)
20225	**Fee:** $244.80 **Benefit:** 75% = $183.60 85% = $208.10
	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)
20230	**Fee:** $244.80 **Benefit:** 75% = $183.60 85% = $208.10
T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	**2. NECK**
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 2. Neck
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units)
20300	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
	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)
20305	**Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
	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)
20320	**Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units)
20321	**Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose and mouth) (8 basic units)
20330	**Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20352	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $244.80 **Benefit:** 75% = $183.60 85% = $208.10

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE **3. THORAX**

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 3. Thorax
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20402	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20403	INITIATION OF MANAGEMENT OF ANAESTHESIA for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20404	INITIATION OF MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20405	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breast using myocutaneous flaps (8 basic units) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
20406	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on

	breast with internal mammary node dissection (13 basic units) **Fee:** $265.20 **Benefit:** 75% = $198.90 85% = $225.45
20410	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20440	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the sternum (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20452	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or sternum (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20472	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
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:** $265.20 **Benefit:** 75% = $198.90 85% = $225.45
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 4. Intrathoracic
20500	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20522	INITIATION OF MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20524	INITIATION OF MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20526	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20528	INITIATION OF MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
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:** $265.20 **Benefit:** 75% = $198.90 85% = $225.45
20542	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
20546	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
20548	INITIATION OF MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea and bronchi (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
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)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	**4. INTRATHORACIC**
	Fee: $408.00 **Benefit:** 75% = $306.00 85% = $346.80

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
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20604	INITIATION OF MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the patient in the sitting position (13 basic units) **Fee:** $265.20 **Benefit:** 75% = $198.90 85% = $225.45
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20622	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic units) **Fee:** $265.20 **Benefit:** 75% = $198.90 85% = $225.45
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:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
20632	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
20634	INITIATION OF MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
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:** $265.20 **Benefit:** 75% = $198.90 85% = $225.45
20680	INITIATION OF MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in the operating theatre of a hospital (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	**5. SPINE AND SPINAL CORD**
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units)
20690	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	**6. UPPER ABDOMEN**
	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
	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)
20700	**Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units)
20702	**Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
	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)
20703	**Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (10 basic units) (See para TN.10.28 of explanatory notes to this Category)
20704	**Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
	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)
20706	**Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units)
20730	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures (5 basic units)
20740	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70

20745	Initiation of the management of anaesthesia for either or both of the following: (a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage; (b) endoscopic retrograde cholangiopancreatography (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20752	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20754	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
20756	INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units) **Fee:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10
20770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
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:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20792	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units) **Fee:** $265.20 **Benefit:** 75% = $198.90 85% = $225.45
20793	INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	6. UPPER ABDOMEN
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic units)
20794	**Fee:** $244.80 **Benefit:** 75% = $183.60 85% = $208.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the upper abdomen (10 basic units)
20798	**Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units)
20799	**Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	7. LOWER ABDOMEN
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 7. Lower Abdomen
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units)
20800	**Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units)
20802	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units)
20803	**Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units) (See para TN.10.28 of explanatory notes to this Category)
20804	**Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units)
20806	**Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
20810	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures (4

	basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20815	INITIATION OF MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to urinary tract (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20832	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
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:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
20842	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20845	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20846	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20847	INITIATION OF MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20848	INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units)

	Fee: $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20850	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units) **Fee:** $244.80 **Benefit:** 75% = $183.60 85% = $208.10
20855	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean hysterectomy or hysterectomy within 24 hours of birth (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20862	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
20863	INITIATION OF MANAGEMENT OF ANAESTHESIA for nephrectomy (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20864	INITIATION OF MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20866	INITIATION OF MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20867	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20868	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient) (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
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:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
20882	INITIATION OF MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20884	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20886	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	**7. LOWER ABDOMEN**
	abdominal organ in the lower abdomen (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	**8. PERINEUM**
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 8. Perineum
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
20902	Initiation of the management of anaesthesia for anorectal procedures (including surgical haemorrhoidectomy, but not banding of haemorrhoids) (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20904	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20906	INITIATION OF MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20912	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder tumour(s) (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20914	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic

	units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
20916	INITIATION OF MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20924	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20926	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20928	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20930	INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20932	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20934	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20936	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
20938	INITIATION OF MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20940	INITIATION OF MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures (including biopsy of vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	8. PERINEUM
	Fee: $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20942	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20943	INITIATION OF MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20944	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
20946	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal birth (8 basic units) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
20948	INITIATION OF MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal of purse string ligature (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20950	INITIATION OF MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20952	INITIATION OF MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
20954	INITIATION OF MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
20956	INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
20960	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40

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)
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21112	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21114	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21116	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
21120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
21140	INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
21150	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
21160	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving symphysis

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	9. PELVIS (EXCEPT HIP)
	pubis or sacroiliac joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21170	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis pubis or sacroiliac joint (8 basic units) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	10. UPPER LEG (EXCEPT KNEE)
	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)
21195	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
21199	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21202	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
21212	INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
21214	INITIATION OF MANAGEMENT OF ANAESTHESIA for total hip replacement or revision (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
21216	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 basic units)

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)
	Fee: $285.60 **Benefit:** 75% = $214.20 85% = $242.80
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
21232	INITIATION OF MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21234	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur (8 basic units) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
21260	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
21272	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
21280	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	11. KNEE AND POPLITEAL AREA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For

	Anaesthesia Performed In Association With An Eligible Service
	Subgroup 11. Knee And Popliteal Area
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21360	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
21382	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
21392	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21402	INITIATION OF MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
21403	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
21404	INITIATION OF MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 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: $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21420	INITIATION OF MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair involving knee joint, undertaken in a hospital (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21432	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or popliteal area (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	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)
21460	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21462	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
21464	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4

	basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21472	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21474	INITIATION OF MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21482	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower leg, ankle or foot (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21484	INITIATION OF MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21486	INITIATION OF MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
21490	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or repair, undertaken in a hospital (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
21502	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21522	INITIATION OF MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21530	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg,

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)
	ankle or foot (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
21532	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8 basic units) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	13. SHOULDER AND AXILLA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 13. Shoulder And Axilla
21600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21622	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21632	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units)

	Fee: $122.40 **Benefit:** 75% = $91.80 85% = $104.05
21634	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units) **Fee:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10
21636	INITIATION OF MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) amputation (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
21638	INITIATION OF MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
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:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
21652	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
21654	INITIATION OF MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or axilla (8 basic units) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
21656	INITIATION OF MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
21670	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
21682	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder spica application when undertaken in a hospital (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40

	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
21700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21712	INITIATION OF MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21714	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21716	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
21732	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21756	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or elbow (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
21760	INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
21770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of upper arm, not

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
	being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
21772	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
21790	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm (15 basic units) **Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	15. FOREARM WRIST AND HAND
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 15. Forearm Wrist And Hand
21800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	15. FOREARM WRIST AND HAND
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units)
21832	**Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint (4 basic units)
21834	**Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units)
21840	**Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units)
21842	**Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units)
21850	**Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, removal, or repair when rendered to a patient as part of an episode of hospital treatment (3 basic units)
21860	**Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units)
21865	(See para TN.10.28 of explanatory notes to this Category) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm, wrist or hand (15 basic units)
21870	**Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (8 basic units)
21872	**Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	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
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
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:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10
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:** $224.40 **Benefit:** 75% = $168.30 85% = $190.75
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:** $265.20 **Benefit:** 75% = $198.90 85% = $225.45
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:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
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:** $346.80 **Benefit:** 75% = $260.10 85% = $294.80
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:** $387.60 **Benefit:** 75% = $290.70 85% = $329.50
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:** $428.40 **Benefit:** 75% = $321.30 85% = $364.15

	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
21900	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for hysterosalpingography (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
21906	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21908	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: cervical (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
21910	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units) **Fee:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10
21912	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: lumbar or thoracic (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21914	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: cervical (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
21915	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21916	INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21918	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21922	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
21925	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units)

	Fee: $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21926	INITIATION OF MANAGEMENT OF ANAESTHESIA for fluoroscopy (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
21930	INITIATION OF MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
21935	INITIATION OF MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21936	INITIATION OF MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time transoesophageal examination (5 basic units) (See para TN.10.26 of explanatory notes to this Category) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21939	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
21942	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures including radio frequency ablation (10 basic units) **Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21945	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or epidural injection (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21949	INITIATION OF MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose of transplantation (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
21952	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units)
21955	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5 basic units)
21959	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units)
21962	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA as a therapeutic procedure if there is a clinical need for anaesthesia, not for headache of any etiology (5 basic units)
21965	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units)
21969	**Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (15 basic units)
21970	**Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed sources (5 basic units)
21973	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic units)
21976	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units)
21980	**Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	18. MISCELLANEOUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 18. Miscellaneous
	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units)
21990	(See para TN.10.12 of explanatory notes to this Category)

	Fee: $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE **19. THERAPEUTIC AND DIAGNOSTIC SERVICES**

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 19. Therapeutic And Diagnostic Services
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
22007	ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
22008	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
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:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
22025	Intra-arterial cannulation when performed in association with the management of anaesthesia in a patient who: (a) is categorised as having a high risk of complications; or (b) develops a high risk of complications during the procedure (4 basic units) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
22031	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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
22036	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:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
22041	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:** $40.80 **Benefit:** 75% = $30.60 85% = $34.70
22042	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:** $20.40 **Benefit:** 75% = $15.30 85% = $17.35
22051	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:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10
22055	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:** $244.80 **Benefit:** 75% = $183.60 85% = $208.10
Amend Fee 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 (Anaes.) (30 basic units) (See para TN.10.10, TN.10.3 of explanatory notes to this Category) **Fee:** $612.00 **Benefit:** 75% = $459.00 85% = $527.30
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:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
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:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10

	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
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
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:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05

	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
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:** $20.40 **Benefit:** 75% = $15.30 85% = $17.35
23025	16 MINUTES TO 30 MINUTES (2 basic units) **Fee:** $40.80 **Benefit:** 75% = $30.60 85% = $34.70
23035	31 MINUTES to 45 MINUTES (3 basic units) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05
23045	46 MINUTES to 1:00 HOUR (4 basic units) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40
23055	1:01 HOURS to 1:15 HOURS (5 basic units) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
23065	1:16 HOURS to 1:30 HOURS (6 basic units) **Fee:** $122.40 **Benefit:** 75% = $91.80 85% = $104.05
23075	1:31 HOURS to 1:45 HOURS (7 basic units) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
23085	1:46 HOURS to 2:00 HOURS (8 basic units) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75
23091	2:01 HOURS TO 2:10 HOURS (9 basic units) **Fee:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10

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
	2:11 HOURS TO 2:20 HOURS (10 basic units)
23101	**Fee:** $204.00 **Benefit:** 75% = $153.00 85% = $173.40
	2:21 HOURS TO 2:30 HOURS (11 basic units)
23111	**Fee:** $224.40 **Benefit:** 75% = $168.30 85% = $190.75
	2:31 HOURS TO 2:40 HOURS (12 basic units)
23112	**Fee:** $244.80 **Benefit:** 75% = $183.60 85% = $208.10
	2:41 HOURS TO 2:50 HOURS (13 basic units)
23113	**Fee:** $265.20 **Benefit:** 75% = $198.90 85% = $225.45
	2:51 HOURS TO 3:00 HOURS (14 basic units)
23114	**Fee:** $285.60 **Benefit:** 75% = $214.20 85% = $242.80
	3:01 HOURS TO 3:10 HOURS (15 basic units)
23115	**Fee:** $306.00 **Benefit:** 75% = $229.50 85% = $260.10
	3:11 HOURS TO 3:20 HOURS (16 basic units)
23116	**Fee:** $326.40 **Benefit:** 75% = $244.80 85% = $277.45
	3:21 HOURS TO 3:30 HOURS (17 basic units)
23117	**Fee:** $346.80 **Benefit:** 75% = $260.10 85% = $294.80
	3:31 HOURS TO 3:40 HOURS (18 basic units)
23118	**Fee:** $367.20 **Benefit:** 75% = $275.40 85% = $312.15
	3:41 HOURS TO 3:50 HOURS (19 basic units)
23119	**Fee:** $387.60 **Benefit:** 75% = $290.70 85% = $329.50
	3:51 HOURS TO 4:00 HOURS (20 basic units)
23121	**Fee:** $408.00 **Benefit:** 75% = $306.00 85% = $346.80
	4:01 HOURS TO 4:10 HOURS (21 basic units)
23170	**Fee:** $428.40 **Benefit:** 75% = $321.30 85% = $364.15
	4:11 HOURS TO 4:20 HOURS (22 basic units)
23180	**Fee:** $448.80 **Benefit:** 75% = $336.60 85% = $381.50
	4:21 HOURS TO 4:30 HOURS (23 basic units)
23190	**Fee:** $469.20 **Benefit:** 75% = $351.90 85% = $398.85
	4:31 HOURS TO 4:40 HOURS (24 basic units)
23200	**Fee:** $489.60 **Benefit:** 75% = $367.20 85% = $416.20

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
	4:41 HOURS TO 4:50 HOURS (25 basic units)
23210	**Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $433.50
	4:51 HOURS TO 5:00 HOURS (26 basic units)
23220	**Fee:** $530.40 **Benefit:** 75% = $397.80 85% = $450.85
	5:01 HOURS TO 5:10 HOURS (27 basic units)
23230	**Fee:** $550.80 **Benefit:** 75% = $413.10 85% = $468.20
	5:11 HOURS TO 5:20 HOURS (28 basic units)
23240	**Fee:** $571.20 **Benefit:** 75% = $428.40 85% = $486.50
	5:21 HOURS TO 5:30 HOURS (29 basic units)
23250	**Fee:** $591.60 **Benefit:** 75% = $443.70 85% = $506.90
	5:31 HOURS TO 5:40 HOURS (30 basic units)
23260	**Fee:** $612.00 **Benefit:** 75% = $459.00 85% = $527.30
	5:41 HOURS TO 5:50 HOURS (31 basic units)
23270	**Fee:** $632.40 **Benefit:** 75% = $474.30 85% = $547.70
	(5:51 HOURS TO 6:00 HOURS (32 basic units)
23280	**Fee:** $652.80 **Benefit:** 75% = $489.60 85% = $568.10
	6:01 HOURS TO 6:10 HOURS (33 basic units)
23290	**Fee:** $673.20 **Benefit:** 75% = $504.90 85% = $588.50
	6:11 HOURS TO 6:20 HOURS (34 basic units)
23300	**Fee:** $693.60 **Benefit:** 75% = $520.20 85% = $608.90
	6:21 HOURS TO 6:30 HOURS (35 basic units)
23310	**Fee:** $714.00 **Benefit:** 75% = $535.50 85% = $629.30
	6:31 HOURS TO 6:40 HOURS (36 basic units)
23320	**Fee:** $734.40 **Benefit:** 75% = $550.80 85% = $649.70
	6:41 HOURS TO 6:50 HOURS (37 basic units)
23330	**Fee:** $754.80 **Benefit:** 75% = $566.10 85% = $670.10
	6:51 HOURS TO 7:00 HOURS (38 basic units)
23340	**Fee:** $775.20 **Benefit:** 75% = $581.40 85% = $690.50
	7:01 HOURS TO 7:10 HOURS (39 basic units)
23350	**Fee:** $795.60 **Benefit:** 75% = $596.70 85% = $710.90

	7:11 HOURS TO 7:20 HOURS (40 basic units)
23360	**Fee:** $816.00 **Benefit:** 75% = $612.00 85% = $731.30
	7:21 HOURS TO 7:30 HOURS (41 basic units)
23370	**Fee:** $836.40 **Benefit:** 75% = $627.30 85% = $751.70
	7:31 HOURS TO 7:40 HOURS (42 basic units)
23380	**Fee:** $856.80 **Benefit:** 75% = $642.60 85% = $772.10
	7:41 HOURS TO 7:50 HOURS (43 basic units)
23390	**Fee:** $877.20 **Benefit:** 75% = $657.90 85% = $792.50
	7:51 HOURS TO 8:00 HOURS (44 basic units)
23400	**Fee:** $897.60 **Benefit:** 75% = $673.20 85% = $812.90
	8:01 HOURS TO 8:10 HOURS (45 basic units)
23410	**Fee:** $918.00 **Benefit:** 75% = $688.50 85% = $833.30
	8:11 HOURS TO 8:20 HOURS (46 basic units)
23420	**Fee:** $938.40 **Benefit:** 75% = $703.80 85% = $853.70
	8:21 HOURS TO 8:30 HOURS (47 basic units)
23430	**Fee:** $958.80 **Benefit:** 75% = $719.10 85% = $874.10
	8:31 HOURS TO 8:40 HOURS (48 basic units)
23440	**Fee:** $979.20 **Benefit:** 75% = $734.40 85% = $894.50
	8:41 HOURS TO 8:50 HOURS (49 basic units)
23450	**Fee:** $999.60 **Benefit:** 75% = $749.70 85% = $914.90
	8:51 HOURS TO 9:00 HOURS (50 basic units)
23460	**Fee:** $1,020.00 **Benefit:** 75% = $765.00 85% = $935.30
	9:01 HOURS TO 9:10 HOURS (51 basic units)
23470	**Fee:** $1,040.40 **Benefit:** 75% = $780.30 85% = $955.70
	9:11 HOURS TO 9:20 HOURS (52 basic units)
23480	**Fee:** $1,060.80 **Benefit:** 75% = $795.60 85% = $976.10
	9:21 HOURS TO 9:30 HOURS (53 basic units)
23490	**Fee:** $1,081.20 **Benefit:** 75% = $810.90 85% = $996.50
	9:31 HOURS TO 9:40 HOURS (54 basic units)
23500	**Fee:** $1,101.60 **Benefit:** 75% = $826.20 85% = $1016.90

	9:41 HOURS TO 9:50 HOURS (55 basic units)
23510	**Fee:** $1,122.00 **Benefit:** 75% = $841.50 85% = $1037.30
	9:51 HOURS TO 10:00 HOURS (56 basic units)
23520	**Fee:** $1,142.40 **Benefit:** 75% = $856.80 85% = $1057.70
	10:01 HOURS TO 10:10 HOURS (57 basic units)
23530	**Fee:** $1,162.80 **Benefit:** 75% = $872.10 85% = $1078.10
	10:11 HOURS TO 10:20 HOURS (58 basic units)
23540	**Fee:** $1,183.20 **Benefit:** 75% = $887.40 85% = $1098.50
	10:21 HOURS TO 10:30 HOURS (59 basic units)
23550	**Fee:** $1,203.60 **Benefit:** 75% = $902.70 85% = $1118.90
	10:31 HOURS TO 10:40 HOURS (60 basic units)
23560	**Fee:** $1,224.00 **Benefit:** 75% = $918.00 85% = $1139.30
	10:41 HOURS TO 10:50 HOURS (61 basic units)
23570	**Fee:** $1,244.40 **Benefit:** 75% = $933.30 85% = $1159.70
	10:51 HOURS TO 11:00 HOURS (62 basic units)
23580	**Fee:** $1,264.80 **Benefit:** 75% = $948.60 85% = $1180.10
	11:01 HOURS TO 11:10 HOURS (63 basic units)
23590	**Fee:** $1,285.20 **Benefit:** 75% = $963.90 85% = $1200.50
	11:11 HOURS TO 11:20 HOURS (64 basic units)
23600	**Fee:** $1,305.60 **Benefit:** 75% = $979.20 85% = $1220.90
	11:21 HOURS TO 11:30 HOURS (65 basic units)
23610	**Fee:** $1,326.00 **Benefit:** 75% = $994.50 85% = $1241.30
	11:31 HOURS TO 11:40 HOURS (66 basic units)
23620	**Fee:** $1,346.40 **Benefit:** 75% = $1009.80 85% = $1261.70
	11:41 HOURS TO 11:50 HOURS (67 basic units)
23630	**Fee:** $1,366.80 **Benefit:** 75% = $1025.10 85% = $1282.10
	11:51 HOURS TO 12:00 HOURS (68 basic units)
23640	**Fee:** $1,387.20 **Benefit:** 75% = $1040.40 85% = $1302.50
	12:01 HOURS TO 12:10 HOURS (69 basic units)
23650	**Fee:** $1,407.60 **Benefit:** 75% = $1055.70 85% = $1322.90

	12:11 HOURS TO 12:20 HOURS (70 basic units)
23660	**Fee:** $1,428.00 **Benefit:** 75% = $1071.00 85% = $1343.30
	12:21 HOURS TO 12:30 HOURS (71 basic units)
23670	**Fee:** $1,448.40 **Benefit:** 75% = $1086.30 85% = $1363.70
	12:31 HOURS TO 12:40 HOURS (72 basic units)
23680	**Fee:** $1,468.80 **Benefit:** 75% = $1101.60 85% = $1384.10
	12:41 HOURS TO 12:50 HOURS (73 basic units)
23690	**Fee:** $1,489.20 **Benefit:** 75% = $1116.90 85% = $1404.50
	12:51 HOURS TO 13:00 HOURS (74 basic units)
23700	**Fee:** $1,509.60 **Benefit:** 75% = $1132.20 85% = $1424.90
	13:01 HOURS TO 13:10 HOURS (75 basic units)
23710	**Fee:** $1,530.00 **Benefit:** 75% = $1147.50 85% = $1445.30
	13:11 HOURS TO 13:20 HOURS (76 basic units)
23720	**Fee:** $1,550.40 **Benefit:** 75% = $1162.80 85% = $1465.70
	13:21 HOURS TO 13:30 HOURS (77 basic units)
23730	**Fee:** $1,570.80 **Benefit:** 75% = $1178.10 85% = $1486.10
	13:31 HOURS TO 13:40 HOURS (78 basic units)
23740	**Fee:** $1,591.20 **Benefit:** 75% = $1193.40 85% = $1506.50
	13:41 HOURS TO 13:50 HOURS (79 basic units)
23750	**Fee:** $1,611.60 **Benefit:** 75% = $1208.70 85% = $1526.90
	13:51 HOURS TO 14:00 HOURS (80 basic units)
23760	**Fee:** $1,632.00 **Benefit:** 75% = $1224.00 85% = $1547.30
	14:01 HOURS TO 14:10 HOURS (81 basic units)
23770	**Fee:** $1,652.40 **Benefit:** 75% = $1239.30 85% = $1567.70
	14:11 HOURS TO 14:20 HOURS (82 basic units)
23780	**Fee:** $1,672.80 **Benefit:** 75% = $1254.60 85% = $1588.10
	14:21 HOURS TO 14:30 HOURS (83 basic units)
23790	**Fee:** $1,693.20 **Benefit:** 75% = $1269.90 85% = $1608.50
	14:31 HOURS TO 14:40 HOURS (84 basic units)
23800	**Fee:** $1,713.60 **Benefit:** 75% = $1285.20 85% = $1628.90

	14:41 HOURS TO 14:50 HOURS (85 basic units)
23810	**Fee:** $1,734.00 **Benefit:** 75% = $1300.50 85% = $1649.30
	14:51 HOURS TO 15:00 HOURS (86 basic units)
23820	**Fee:** $1,754.40 **Benefit:** 75% = $1315.80 85% = $1669.70
	15:01 HOURS TO 15:10 HOURS (87 basic units)
23830	**Fee:** $1,774.80 **Benefit:** 75% = $1331.10 85% = $1690.10
	15:11 HOURS TO 15:20 HOURS (88 basic units)
23840	**Fee:** $1,795.20 **Benefit:** 75% = $1346.40 85% = $1710.50
	15:21 HOURS TO 15:30 HOURS (89 basic units)
23850	**Fee:** $1,815.60 **Benefit:** 75% = $1361.70 85% = $1730.90
	15:31 HOURS TO 15:40 HOURS (90 basic units)
23860	**Fee:** $1,836.00 **Benefit:** 75% = $1377.00 85% = $1751.30
	15:41 HOURS TO 15:50 HOURS (91 basic units)
23870	**Fee:** $1,856.40 **Benefit:** 75% = $1392.30 85% = $1771.70
	15:51 HOURS TO 16:00 HOURS (92 basic units)
23880	**Fee:** $1,876.80 **Benefit:** 75% = $1407.60 85% = $1792.10
	16:01 HOURS TO 16:10 HOURS (93 basic units)
23890	**Fee:** $1,897.20 **Benefit:** 75% = $1422.90 85% = $1812.50
	16:11 HOURS TO 16:20 HOURS (94 basic units)
23900	**Fee:** $1,917.60 **Benefit:** 75% = $1438.20 85% = $1832.90
	16:21 HOURS TO 16:30 HOURS (95 basic units)
23910	**Fee:** $1,938.00 **Benefit:** 75% = $1453.50 85% = $1853.30
	16:31 HOURS TO 16:40 HOURS (96 basic units)
23920	**Fee:** $1,958.40 **Benefit:** 75% = $1468.80 85% = $1873.70
	16:41 HOURS TO 16:50 HOURS (97 basic units)
23930	**Fee:** $1,978.80 **Benefit:** 75% = $1484.10 85% = $1894.10
	16:51 HOURS TO 17:00 HOURS (98 basic units)
23940	**Fee:** $1,999.20 **Benefit:** 75% = $1499.40 85% = $1914.50
	17:01 HOURS TO 17:10 HOURS (99 basic units)
23950	**Fee:** $2,019.60 **Benefit:** 75% = $1514.70 85% = $1934.90

	17:11 HOURS TO 17:20 HOURS (100 basic units)
23960	**Fee:** $2,040.00 **Benefit:** 75% = $1530.00 85% = $1955.30
	17:21 HOURS TO 17:30 HOURS (101 basic units)
23970	**Fee:** $2,060.40 **Benefit:** 75% = $1545.30 85% = $1975.70
	17:31 HOURS TO 17:40 HOURS (102 basic units)
23980	**Fee:** $2,080.80 **Benefit:** 75% = $1560.60 85% = $1996.10
	17:41 HOURS TO 17:50 HOURS (103 basic units)
23990	**Fee:** $2,101.20 **Benefit:** 75% = $1575.90 85% = $2016.50
	17:51 HOURS TO 18:00 HOURS (104 basic units)
24100	**Fee:** $2,121.60 **Benefit:** 75% = $1591.20 85% = $2036.90
	18:01 HOURS TO 18:10 HOURS (105 basic units)
24101	**Fee:** $2,142.00 **Benefit:** 75% = $1606.50 85% = $2057.30
	18:11 HOURS TO 18:20 HOURS (106 basic units)
24102	**Fee:** $2,162.40 **Benefit:** 75% = $1621.80 85% = $2077.70
	18:21 HOURS TO 18:30 HOURS (107 basic units)
24103	**Fee:** $2,182.80 **Benefit:** 75% = $1637.10 85% = $2098.10
	18:31 HOURS TO 18:40 HOURS (108 basic units)
24104	**Fee:** $2,203.20 **Benefit:** 75% = $1652.40 85% = $2118.50
	18:41 HOURS TO 18:50 HOURS (109 basic units)
24105	**Fee:** $2,223.60 **Benefit:** 75% = $1667.70 85% = $2138.90
	18:51 HOURS TO 19:00 HOURS (110 basic units)
24106	**Fee:** $2,244.00 **Benefit:** 75% = $1683.00 85% = $2159.30
	19:01 HOURS TO 19:10 HOURS (111 basic units)
24107	**Fee:** $2,264.40 **Benefit:** 75% = $1698.30 85% = $2179.70
	19:11 HOURS TO 19:20 HOURS (112 basic units)
24108	**Fee:** $2,284.80 **Benefit:** 75% = $1713.60 85% = $2200.10
	19:21 HOURS TO 19:30 HOURS (113 basic units)
24109	**Fee:** $2,305.20 **Benefit:** 75% = $1728.90 85% = $2220.50
	19:31 HOURS TO 19:40 HOURS (114 basic units)
24110	**Fee:** $2,325.60 **Benefit:** 75% = $1744.20 85% = $2240.90

	19:41 HOURS TO 19:50 HOURS (115 basic units)
24111	**Fee:** $2,346.00 **Benefit:** 75% = $1759.50 85% = $2261.30
	19:51 HOURS TO 20:00 HOURS (116 basic units)
24112	**Fee:** $2,366.40 **Benefit:** 75% = $1774.80 85% = $2281.70
	20:01 HOURS TO 20:10 HOURS (117 basic units)
24113	**Fee:** $2,386.80 **Benefit:** 75% = $1790.10 85% = $2302.10
	20:11 HOURS TO 20:20 HOURS (118 basic units)
24114	**Fee:** $2,407.20 **Benefit:** 75% = $1805.40 85% = $2322.50
	20:21 HOURS TO 20:30 HOURS (119 basic units)
24115	**Fee:** $2,427.60 **Benefit:** 75% = $1820.70 85% = $2342.90
	20:31 HOURS TO 20:40 HOURS (120 basic units)
24116	**Fee:** $2,448.00 **Benefit:** 75% = $1836.00 85% = $2363.30
	20:41 HOURS TO 20:50 HOURS (121 basic units)
24117	**Fee:** $2,468.40 **Benefit:** 75% = $1851.30 85% = $2383.70
	20:51 HOURS TO 21:00 HOURS (122 basic units)
24118	**Fee:** $2,488.80 **Benefit:** 75% = $1866.60 85% = $2404.10
	21:01 HOURS TO 21:10 HOURS (123 basic units)
24119	**Fee:** $2,509.20 **Benefit:** 75% = $1881.90 85% = $2424.50
	21:11 HOURS TO 21:20 HOURS (124 basic units)
24120	**Fee:** $2,529.60 **Benefit:** 75% = $1897.20 85% = $2444.90
	21:21 HOURS TO 21:30 HOURS (125 basic units)
24121	**Fee:** $2,550.00 **Benefit:** 75% = $1912.50 85% = $2465.30
	21:31 HOURS TO 21:40 HOURS (126 basic units)
24122	**Fee:** $2,570.40 **Benefit:** 75% = $1927.80 85% = $2485.70
	21:41 HOURS TO 21:50 HOURS (127 basic units)
24123	**Fee:** $2,590.80 **Benefit:** 75% = $1943.10 85% = $2506.10
	21:51 HOURS TO 22:00 HOURS (128 basic units)
24124	**Fee:** $2,611.20 **Benefit:** 75% = $1958.40 85% = $2526.50
	22:01 HOURS TO 22:10 HOURS (129 basic units)
24125	**Fee:** $2,631.60 **Benefit:** 75% = $1973.70 85% = $2546.90

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
	22:11 HOURS TO 22:20 HOURS (130 basic units)
24126	**Fee:** $2,652.00 **Benefit:** 75% = $1989.00 85% = $2567.30
	22:21 HOURS TO 22:30 HOURS (131 basic units)
24127	**Fee:** $2,672.40 **Benefit:** 75% = $2004.30 85% = $2587.70
	22:31 HOURS TO 22:40 HOURS (132 basic units)
24128	**Fee:** $2,692.80 **Benefit:** 75% = $2019.60 85% = $2608.10
	22:41 HOURS TO 22:50 HOURS (133 basic units)
24129	**Fee:** $2,713.20 **Benefit:** 75% = $2034.90 85% = $2628.50
	22:51 HOURS TO 23:00 HOURS (134 basic units)
24130	**Fee:** $2,733.60 **Benefit:** 75% = $2050.20 85% = $2648.90
	23:01 HOURS TO 23:10 HOURS (135 basic units)
24131	**Fee:** $2,754.00 **Benefit:** 75% = $2065.50 85% = $2669.30
	23:11 HOURS TO 23:20 HOURS (136 basic units)
24132	**Fee:** $2,774.40 **Benefit:** 75% = $2080.80 85% = $2689.70
	23:21 HOURS TO 23:30 HOURS (137 basic units)
24133	**Fee:** $2,794.80 **Benefit:** 75% = $2096.10 85% = $2710.10
	23:31 HOURS TO 23:40 HOURS (138 basic units)
24134	**Fee:** $2,815.20 **Benefit:** 75% = $2111.40 85% = $2730.50
	23:41 HOURS TO 23:50 HOURS (139 basic units)
24135	**Fee:** $2,835.60 **Benefit:** 75% = $2126.70 85% = $2750.90
	23:51 HOURS TO 24:00 HOURS (140 basic units)
24136	**Fee:** $2,856.00 **Benefit:** 75% = $2142.00 85% = $2771.30

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN 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
	ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA
25000	(a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to

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
	22905; or (b) for perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $20.40 **Benefit:** 75% = $15.30 85% = $17.35
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) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $40.80 **Benefit:** 75% = $30.60 85% = $34.70
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) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN 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
25013 S	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged under 4 years (Anaes.) (1 basic units) **Fee:** $20.40 **Benefit:** 75% = $15.30 85% = $17.35
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:** $20.40 **Benefit:** 75% = $15.30 85% = $17.35
25020	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $40.80 **Benefit:** 75% = $30.60 85% = $34.70

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
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) (See para TN.10.3 of explanatory notes to this Category) **Derived Fee:** An additional amount of 50% of fee for the anaesthetic service.That is:(a) an anaesthesia item/s range 20100 - 21997 or 22900, plus (b)an item range 23010 - 24136, plus(c) if applicable,an item range 25000-25014, plus(d) where performed, any assoc therapeutic or diagnostic service range 22002-22051
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) (See para TN.10.3 of explanatory notes to this Category) **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
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) (See para TN.10.3 of explanatory notes to this Category) **Derived Fee:** An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item range 23010 - 24136, plus (c) where applicable, an item range 25000 - 25014, plus (d) where performed, 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

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	26. ASSISTANCE AT ANAESTHESIA
	Subgroup 26. Assistance At Anaesthesia
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 $102.00 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051
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 $102.00 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051

T11. BOTULINUM TOXIN INJECTIONS	
	Group T11. Botulinum Toxin Injections
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:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
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:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
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:** $257.55 **Benefit:** 75% = $193.20 85% = $218.95

T11. BOTULINUM TOXIN INJECTIONS	
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 of explanatory notes to this Category) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
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) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
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:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
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

T11. BOTULINUM TOXIN INJECTIONS	
	(c) the patient has not had treatment with botulinum toxin within the immediately preceding 4 months; and (d) if the patient has had treatment with botulinum toxin within the previous 12 months - the patient had treatment on no more than 2 separate occasions (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $254.40 **Benefit:** 75% = $190.80 85% = $216.25
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:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $161.30 **Benefit:** 75% = $121.00 85% = $137.15
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:** $275.35 **Benefit:** 75% = $206.55 85% = $234.05
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:** $46.45 **Benefit:** 75% = $34.85 85% = $39.50
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:** $46.45 **Benefit:** 75% = $34.85 85% = $39.50
18372	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of

T11. BOTULINUM TOXIN INJECTIONS	
	bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
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:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
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 (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

T11. BOTULINUM TOXIN INJECTIONS	
	urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $237.05 **Benefit:** 75% = $177.80
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:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
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 (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:** $237.05 **Benefit:** 75% = $177.80

INDEX

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

X

Z