Irish Life health

Schedule of Benefits

for Professional Fees 2019

Anaesthesia

ANAESTHESIA

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Attendance	191	General anaesthesia for gastroscopy procedures (codes 192, 194, 198 or 206) and colonoscopy procedures (codes 450, 455, 456, 457, 458, 459, 530, 535 or 536) in children under 16 years of age	No		
Attendance	2207	Epidural anaesthesia for vaginal delivery	No		
Attendance	192201	General anaesthesia for diagnostic scans, for child under the age of 2	Yes		
Attendance	192202	General anaesthesia for children under the age of 12, procedure not specified	No		
Attendance	192203	General anaesthesia for diagnostic scans, for adults	Yes		
Attendance	192204	General anaesthesia for adults, procedure not specified	Yes		

CARDIOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Ablation	938407	Intracardiac electrophysiology studies with catheter ablation of arrhythmogenic left atrial focus/ foci for treatment of atrial fibrillation; linear or focal ablation, including pulmonary vein isolation (includes transseptal catheterisation)	No	Procedure codes 5961, 5024 and 5029 may not be claimed in conjunction with procedure code 5502	Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Angiogram	5058	Cardiac catheterisation and coronary angiography with or without ventriculography with fractional flow reserve (FFR) intracoronary pressure measurements	No	Diagnostic, Day Care	Please confirm which of the following conditions are met for: (a) Patients with angina pectoris or other symptoms triggered by exertion who have: (i) ST segment depression greater than 1.5mm to 2mm appearing at low work load and/ or low rate pressure product in exercise stress testing suggesting a significant myocardial ischemia (ii) Diagnostic work-up of unexplained chest pain when exercise stress test is equivocal and does not establish the diagnosis and the probability of coronary heart disease is increased (iii) Significant perfusion defect in myocardial perfusion scan or findings in exercise echocardiography indicating myocardial ischemia (b) Patient with acute chest pain with: (i) ST elevation myocardial infarction (ii) Non-ST segment elevation myocardial infarction and unstable angina pectoris (iii) Heart failure of unknown aetiology (iv) Requiring further investigation following surviving resuscitation after ventricular fibrillation (v) In association with invasive assessment of valvular heart disease (vi) Assessment prior to heart transplantation For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure

CARDIOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Angiogram	5090	Cardiac catheterisation and coronary angiography with or without ventriculography	No	Diagnostic, Day Care	Please confirm which of the following conditions are met for: (a) Patients with angina pectoris or other symptoms triggered by exertion who have: (i) ST segment depression greater than 1.5mm to 2mm appearing at low work load and/ or low rate pressure product in exercise stress testing suggesting a significant myocardial ischemia (ii) Diagnostic work-up of unexplained chest pain when exercise stress test is equivocal and does not establish the diagnosis and the probability of coronary heart disease is increased (iii) Significant perfusion defect in myocardial perfusion scan or findings in exercise echocardiography indicating myocardial ischemia (b) Patient with acute chest pain with (i) ST elevation myocardial infarction (ii) Non-ST segment elevation myocardial infarction and unstable angina pectoris (iii) Heart failure of unknown aetiology (iv) Patient requires further investigation having surviving resuscitation after ventricular fibrillation (v) Assessment prior to heart transplantation For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Angiogram	5200	Transeptal left heart catheterisation (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Cardioversion	5091	Cardioversion	No	Day Care	For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Cardioversion	930991	Combination cardioversion (code 5091) and TOE (code 5109) (see codes for full description)	No	Day Care	Codes 5108 or 5008 are not payable in addition to this code Rules as set out in codes 5091 and 5109 will continue to apply
Electrophysiologic Studies	5079	Biventricular pacing - insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system)	No		Payable in full when carried out with 5028, 5071,5072, 5073, 5074, 5076, 5077, 5201 and 5202 For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Electrophysiologic Studies	5502	Comprehensive electrophysiological evaluation with right atrial pacing and recording, right ventricular pacing and recording, HIS bundle recording, including insertion and repositioning of multiple electrode catheters.	No	Day Care	Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Electrophysiologic Studies	5960	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure

CARDIOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Electrophysiologic Studies	5961	Intracardiac catheter ablation of arrhythmogenic focus for treatment of supraventricular or ventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, (including foci pulmonary vein) single or in combination	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Electrophysiologic Studies	938403	Intracardiac electrophysiological studies with catheter ablation for treatment of ventricular arrhythmia or ectopic focus/foci, or for patients with a history of congenital heart anomalies	No	Procedure codes 5961, 5024 and 5029 may not be claimed in conjunction with procedure code 5502	Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Pacemaker	5063	Removal of single or dual chamber pacing cardioverter/ defibrillator electrode(s); by transvenous extraction	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Pacemaker	5065	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Pacemaker	5069	Insertion of automatic implantable cardioverter/ defibrillator, single, dual or biventricular	No		Possible co-payment please check Table of Cover Please specify whether single/ dual or bivent Please indicate which of the following conditions are met on the claim form: (a) Survivor of cardiac arrest due to VF or hemodynamically unstable sustained VT after evaluation to define the cause of the event and to exclude any completely reversible causes (b) Structural heart disease and spontaneous sustained VT, whether hemodynamically stable or unstable (c) Syncope of undetermined origin with clinically relevant, hemodynamically significant sustained VT or VF induced at EP study. (d) LVEF < 35% due to prior MI who are at least 40 days post MI and are in NYHA functional Class 1 or 2 (e) Non ischemic DCM who have LVEF < 35% and who are NYHA functional Class 2 or 3 (f) LV dysfunction due to prior MI who are at least 40 days post MI and have an LVEF < 30% and are NYHA Class 1 (g) Non sustained VY due top prior MI, LVEF <40% and inducible VF or sustained VT at EP study (h) Unexpected syncope, significant LV dysfunction and non ischemic DCM (i) Sustained VT and normal or near normal ventricular function (j) HCM with one or more risk factors for SCD (k) Prevention of SCD in patients with ARVD/C who have had one or more factors for SCD (l) To reduce bet blockers in patients with long QT syndrome who are experience syncope and/ or VT receiving beta blocker (m) Non-hospitalised patients awaiting transplantation (n) Patients with Brugada syndrome who have had syncope (o) Brugada syndrome with documented VT that has not resulted in cardiac arrest (p) Catecholamingic polymorphic VT with syncope and/ or documented sustained VT while receiving beta blockers (q) Cardiac sarcoidosis, giant cell myocarditis or Chagas disease
Pacemaker	5071	Insertion or replacement of permanent pacemaker with transvenous electrode(s); single chamber	No		Possible co-payment please check Table of Cover Includes repositioning or replacement in the first 14 days after the insertion (or replacement) of the device For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure

CARDIOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Pacemaker	5072	Insertion or replacement of permanent pacemaker with transvenous electrode(s); dual chamber	No		Possible co-payment please check Table of Cover Includes repositioning or replacement in the first 14 days after the insertion (or replacement) of the device For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Pacemaker	5073	Insertion or replacement of pacemaker pulse generator only; single chamber atrial or ventricular	No		Possible co-payment please check Table of Cover Includes repositioning or replacement in the first 14 days after the insertion (or replacement) of the device For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Pacemaker	5074	Insertion or replacement of pacemaker pulse generator only (includes defibrillator pulse generator); dual chamber	No		Possible co-payment please check Table of Cover Includes repositioning or replacement in the first 14 days after the insertion (or replacement) of the device For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Pacemaker	5076	Insertion, replacement or repositioning of permanent transvenous electrode(s) only (15 days or more after initial insertion); single chamber	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Pacemaker	5077	Insertion, replacement or repositioning of permanent transvenous electrode(s) only (15 days or more after initial insertion); dual chamber	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Pacemaker	938400	Insertion or repositioning of permanent transvenous cardiac electrode(s) and lead(s) - 15 days or more after initial insertion	No		Possible co-payment please check Table of Cover
Pacemaker	938401	Extraction of transvenous permanent pacemaker electrode - single lead - 15 days or more after initial insertion	No	Prosthesis benefit is only payable where this procedure is performed during same theatre session as procedure code 5001 (i.e. insertion of new electrode).	Possible co-payment please check Table of Cover

CARDIOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Pacemaker	938402	Extraction of transvenous permanent pacemaker electrodes, multiple leads	No	Prosthesis benefit is only payable where this procedure is performed during same theatre session as procedure code 5001 (i.e. insertion of new electrode).	Possible co-payment please check Table of Cover
Pacemaker	938404	Insertion of automatic implantable cardioverter/ defibrillator, single chamber	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Pacemaker	938405	Insertion of automatic implantable cardioverter/ defibrillator, dual chamber	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Pacemaker	938406	Insertion of automatic implantable cardioverter/ defibrillator, biventricular	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Paediatric Cardiology	5089	Trans-oesophageal echocardiography for congenital cardiac anomalies in children under 16 years of age; including probe placement, image acquisition, interpretation and report	No	Diagnostic, Side Room	For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Paediatric Cardiology	5093	Paediatric cardiac catheterisation (left, right or both sides)	No	Diagnostic	For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Paediatric Cardiology	5094	Paediatric cardiac catheterisation and cardiac angiography combined	No	Diagnostic	For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
PTCA	5115	Percutaneous transcatheter closure of congenital interatrial communication (i.e. Fontan fenestration, atrial septal defect) with implant, including right heart catheterisation	No	Day Care	Possible co-payment please check Table of Cover Procedure codes 5115 and 5119 include right heart catheterisation For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure

CARDIOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
PTCA	5119	Percutaneous transcatheter closure of congenital ventricular septal defect with implant including right heart catheterisation	No		Possible co-payment please check Table of Cover Procedure codes 5115 and 5119 include right heart catheterisation For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
TAVI	5133	Transcatheter aortic valve implantation (TAVI) for aortic stenosis (Edwards Sapien) (I.P.)	Yes	Independent Procedure	Possible co-payment please check Table of Cover For patients with aortic stenosis for whom surgical aortic valve replacement is considered unsuitable Clinicians wishing to undertake TAVI for aortic stenosis in patients who are at high risk for surgical valve replacement should ensure that patients understand the risk of stroke and death, and the uncertainty about the procedure's efficacy in the long term. Provide them with clear written information In addition evidence of patient selection should be carried out by a multidisciplinary team including interventional cardiologists, cardiac surgeons, a cardiac anaesthetist and an expert in cardiac imaging The multidisciplinary team should determine the risk level of each patient and must be named in the request for approval. TAVI may only be performed only by clinicians and teams with special training and experience in cardiovascular interventions and in units undertaking which have both cardiac and vascular surgical support for emergency treatment of complications Such facilities must request approval from Irish Life Health for inclusion on the Irish Life Health list of such facilities For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure

DENTAL / ORAL / PERIODONTAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Coronectomy	29761	The planned surgical removal of the crown of an impacted tooth to preserve the inferior dental nerve, where radiographic evidence suggests the nerve is at risk on complete tooth removal	Yes	Side Room	Payable to Consultant Maxillofacial Surgeon and Oral Surgeon/ Orthodontist on the Specialist Register maintained by the Dental Council and approved Periodontists
Coronectomy	418996	Coronectomy	Yes	Day Care	An alternative treatment to complete extraction due to potential neurovascular injury as a result of the proximity of roots to the inferior alveolar nerve
Gingivectomy	2953	Gingivectomy, one to four teeth	Yes	Side Room	Gingivectomy is taken to include the removal of surface deposits from the roots For codes 2953, 2954, and 2956 benefit is only approved in cases of severe gingival hyperplasia and which, in the opinion of Irish Life Health's dental advisors, are not treatable by conservative methods Prior notification including full clinical details, radiographs, or if more appropriate, photographs and pocket depths, should be sent to Irish Life Health for this purpose It is necessary to provide the deepest pocket depth for each tooth involved in gingival/ periodontal surgery on the pocket depth chart in order to have pre-certification approval
Gingivectomy	2954	Gingivectomy, five to eleven teeth	Yes	Side Room	Gingivectomy is taken to include the removal of surface deposits from the roots For codes 2953, 2954, and 2956 benefit is only approved in cases of severe gingival hyperplasia and which, in the opinion of Irish Life Health's dental advisors, are not treatable by conservative methods Prior notification including full clinical details, radiographs, or if more appropriate, photographs and pocket depths, should be sent to Irish Life Health for this purpose It is necessary to provide the deepest pocket depth for each tooth involved in gingival/ periodontal surgery on the pocket depth chart in order to have pre-certification approval

DENTAL / ORAL / PERIODONTAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Gingivectomy	2956	Gingivectomy, twelve or more teeth	Yes	Side Room	Gingivectomy is taken to include the removal of surface deposits from the roots For codes 2953, 2954, and 2956 benefit is only approved in cases of severe gingival hyperplasia and which, in the opinion of Irish Life Health's dental advisors, are not treatable by conservative methods Prior notification including full clinical details, radiographs, or if more appropriate, photographs and pocket depths, should be sent to Irish Life Health for this purpose It is necessary to provide the deepest pocket depth for each tooth involved in gingival/ periodontal surgery on the pocket depth chart in order to have pre-certification approval
Impacted Tooth	2973	Removal of one upper impacted or unerupted tooth	Yes	Day Care	
Impacted Tooth	2974	Removal of two upper impacted or unerupted teeth	Yes	Day Care	
Impacted Tooth	2976	Removal of one lower impacted or unerupted tooth	Yes	Side Room	
Impacted Tooth	2977	Removal of two lower impacted or unerupted teeth	Yes	Day Care	
Impacted Tooth	2978	Removal of one impacted or unerupted canine tooth	Yes	Day Care	
Impacted Tooth	2979	Removal of two impacted or unerupted canine teeth	Yes	Day Care	
Impacted Tooth	2981	Removal of four or more impacted or unerupted teeth	Yes	Day Care	
Impacted Tooth	2982	Removal of three impacted or unerupted teeth which includes two lower teeth	Yes	Day Care	
Impacted Tooth	2983	Removal of three impacted or unerupted teeth which includes two upper teeth	Yes	Day Care	
Impacted Tooth	2984	Removal of one upper and one lower impacted or unerupted tooth	Yes	Day Care	
Impacted Tooth	3001	Surgical exposure and repositioning of an impacted tooth	Yes	Day Care	
Impacted Tooth	3002	Surgical exposure and repositioning of impacted teeth	Yes	Day Care	
Impacted Tooth	3032	Removal of an impacted or unerupted tooth in a patient 16 years or younger under general anaesthetic	Yes	Day Care	Payable to consultant Maxillofacial Surgeon and Oral Surgeon/ Orthodontist on the Specialist Register maintained by the Dental Council and approved Periodontists
Impacted Tooth	3033	Removal of two impacted or unerupted teeth in a patient 16 years or younger under general anaesthetic	Yes	Day Care	Payable to consultant Maxillofacial Surgeon and Oral Surgeon/ Orthodontist on the Specialist Register maintained by the Dental Council and approved Periodontists
Impacted Tooth	3036	Open surgical exposure of a single impacted tooth in compact bone in patients 16 years or younger	No	Day Care	Payable to consultant Maxillofacial Surgeon and Oral Surgeon/ Orthodontist on the Specialist Register maintained by the Dental Council and approved Periodontists, no preapproval required
Maxillo Facial	3011	Temporomandibular joint, reconstruction osteotomy of ramus and joint with costochondral graft (I.P.)	No	Independent Procedure	No preapproval required
Maxillo Facial	3012	Temporomandibular joint, open surgical correction of dislocation (I.P.)	No	Independent Procedure	No preapproval required
Maxillo Facial	3013	Le Fort I osteotomy (includes segmental or cleft) with or without graft	No		No preapproval required
Maxillo Facial	3014	Le Fort II osteotomy (includes via bicoronal flap) with or without graft	No		No preapproval required

DENTAL / ORAL / PERIODONTAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Maxillo Facial	3016	Osseointegrated mandibular implant including second stage abutment installation	Yes	Side Room	The professional fee benefit as detailed in this schedule is payable for non-cosmetic osseointegrated mandibular implants This benefit is restricted to those who otherwise would be unable to wear a conventional full denture on the lower arch Benefit is not payable for implants where: (a) A patient is partially dentate in the lower arch (b) A patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exceptional circumstances In addition, a grant-in-aid of €532.29 is payable per implant towards the cost of the implant components
Maxillo Facial	3017	Two osseointegrated mandibular implants including second stage abutment installation	Yes	Side Room	The professional fee benefit as detailed in this schedule is payable for non-cosmetic osseointegrated mandibular implants This benefit is restricted to those who otherwise would be unable to wear a conventional full denture on the lower arch Benefit is not payable for implants where: (a) A patient is partially dentate in the lower arch (b) A patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exceptional circumstances In addition, a grant-in-aid of €532.29 is payable per implant towards the cost of the implant components
Maxillo Facial	3018	Three osseointegrated mandibular implants including second stage abutment installation	Yes	Side Room	The professional fee benefit as detailed in this schedule is payable for non-cosmetic osseointegrated mandibular implants This benefit is restricted to those who otherwise would be unable to wear a conventional full denture on the lower arch Benefit is not payable for implants where: (a) A patient is partially dentate in the lower arch (b) A patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exceptional circumstances In addition, a grant-in-aid of €532.29 is payable per implant towards the cost of the implant components
Maxillo Facial	3019	Four osseointegrated mandibular implants including second stage abutment installation	Yes	Side Room	The professional fee benefit as detailed in this schedule is payable for non-cosmetic osseointegrated mandibular implants This benefit is restricted to those who otherwise would be unable to wear a conventional full denture on the lower arch Benefit is not payable for implants where: (a) A patient is partially dentate in the lower arch (b) A patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exceptional circumstances In addition, a grant-in-aid of €532.29 is payable per implant towards the cost of the implant components
Maxillo Facial	3021	Five osseointegrated mandibular implants including second stage abutment installation	Yes	Side Room	The professional fee benefit as detailed in this schedule is payable for non-cosmetic osseointegrated mandibular implants This benefit is restricted to those who otherwise would be unable to wear a conventional full denture on the lower arch Benefit is not payable for implants where: (a) A patient is partially dentate in the lower arch (b) A patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exceptional circumstances In addition, a grant-in-aid of € 532.29 is payable per implant towards the cost of the implant components
Maxillo Facial	3022	Six or more osseointegrated mandibular implants including second stage abutment installation	Yes	Side Room	The professional fee benefit as detailed in this schedule is payable for non-cosmetic osseointegrated mandibular implants This benefit is restricted to those who otherwise would be unable to wear a conventional full denture on the lower arch Benefit is not payable for implants where: (a) A patient is partially dentate in the lower arch (b) A patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exceptional circumstances In addition, a grant-in-aid of €532.29 is payable per implant towards the cost of the implant components
Maxillo Facial	3024	Le Fort III osteotomy via bicoronal flap with or without graft with Le Fort I	No		No preapproval required
Maxillo Facial	3026	Reconstruction midface, osteotomies (other than Le Fort I type) and bone grafts (includes obtaining autografts) (includes via bicoronal flap)	No		No preapproval required
Maxillo Facial	3027	Sagittal split osteotomy with or without graft	No		No preapproval required
Maxillo Facial	3028	Vertical ramus osteotomy, intraoral or extraoral with or without graft	No		No preapproval required

DENTAL / ORAL / PERIODONTAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Maxillo Facial	3029	Zygomatic osteotomy, unilateral	No		No preapproval required
Maxillo Facial	3030	Tuberosity's, reduction of	No	Side Room	
Maxillo Facial	430310	Osteotomy segmental of maxilla and mandible	No		No preapproval required
Odontoma	2985	Odontoma, excision of (I.P.)	No	Independent Procedure, Day Care	No preapproval required
Odontoma	3034	Surgical removal of odontoma(s) in a patient 16 years or younger under general anaesthetic	No	Day Care	Payable to consultant Maxillofacial Surgeon and Oral Surgeon/ Orthodontist on the Specialist Register maintained by the Dental Council and approved Periodontists, no preapproval required
Other Dental Procedures	2940	Dental cysts of maxilla or mandible	No	Day Care	Cystic tissue removed in the process of tooth or root resection and extractions, surgical or otherwise, is considered to be an integral part of that surgical treatment and is not a separate procedure, no preapproval required
Other Dental Procedures	2980	Labial frenectomy with dissection of tissue	No	Side Room	No preapproval required
Other Dental Procedures	3015	Reimplantation of tooth in socket with splinting	No	Side Room	No preapproval required
Other Dental Procedures	3020	Simple cysts or epulis, palate or floor of mouth, excision of	No	Side Room	No preapproval required
Other Dental Procedures	3025	Small tumours of dental origin, removal of, includes biopsy	No	Side Room	No preapproval required
Other Dental Procedures	3037	Open surgical exposure of two teeth in compact bone in patients 16 years or younger	No	Day Care	Payable to consultant Maxillofacial Surgeon and Oral Surgeon/ Orthodontist on the Specialist Register maintained by the Dental Council and approved Periodontists, no preapproval required
Peridontal Procedure	2996	Periodontal mucoperiosteal flap surgery, one to four teeth	Yes	Side Room	For codes 2996, 2997 and 2998 the term periodontal mucoperiosteal flap surgery is used to denote the incisions and subsequent elevation of a mucogingival flap in order to gain access to tooth roots for the purpose of root planning, surettage, osseous surgery and placements of grafts Benefit only applies when flaps are raised in order to gain access to periodontal sites where pocket depths are 6mm or more ILH have been advised that periodontal surgical procedures have been replaced by more conservative (closed) methods of treatment, such as root planning or scaling These procedures are not covered by Irish Life Health In exceptional cases, where serious periodontal disease is present which, in the opinion of Irish Life Health's dental advisors, is not treatable by conservative methods and where pocket depths are 6mm or more, Irish Life Health will consider such cases for payment Prior notification, including full clinical details, relevant radiographs and pocket depths, should be sent to Irish Life Health for this purpose It is necessary to provide the deepest pocket depth for each tooth involved in gingival/ periodontal surgery on the pocket depths chart in order to have precertification approval
Peridontal Procedure	2997	Periodontal mucoperiosteal flap surgery, five to eleven teeth	Yes	Side Room	For codes 2996, 2997 and 2998 the term periodontal mucoperiosteal flap surgery is used to denote the incisions and subsequent elevation of a mucogingival flap in order to gain access to tooth roots for the purpose of root planning, surettage, osseous surgery and placements of grafts Benefit only applies when flaps are raised in order to gain access to periodontal sites where pocket depths are 6mm or more ILH have been advised that periodontal surgical procedures have been replaced by more conservative (closed) methods of treatment, such as root planning or scaling These procedures are not covered by Irish Life Health In exceptional cases, where serious periodontal disease is present which, in the opinion of Irish Life Health's dental advisors, is not treatable by conservative methods and where pocket depths are 6mm or more, Irish Life Health will consider such cases for payment Prior notification, including full clinical details, relevant radiographs and pocket depths, should be sent to Irish Life Health for this purpose It is necessary to provide the deepest pocket depth for each tooth involved in gingival/ periodontal surgery on the pocket depths chart in order to have precertification approval

DENTAL / ORAL / PERIODONTAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Peridontal Procedure	2998	Periodontal mucoperiosteal flap surgery, twelve or more teeth	Yes	Side Room	For codes 2996, 2997 and 2998 the term periodontal mucoperiosteal flap surgery is used to denote the incisions and subsequent elevation of a mucogingival flap in order to gain access to tooth roots for the purpose of root planning, surettage, osseous surgery and placements of grafts Benefit only applies when flaps are raised in order to gain access to periodontal sites where pocket depths are 6mm or more ILH have been advised that periodontal surgical procedures have been replaced by more conservative (closed) methods of treatment, such as root planning or scaling These procedures are not covered by Irish Life Health In exceptional cases, where serious periodontal disease is present which, in the opinion of Irish Life Health's dental advisors, is not treatable by conservative methods and where pocket depths are 6mm or more, Irish Life Health will consider such cases for payment Prior notification, including full clinical details, relevant radiographs and pocket depths, should be sent to Irish Life Health for this purpose It is necessary to provide the deepest pocket depth for each tooth involved in gingival/ periodontal surgery on the pocket depths chart in order to have precertification approval
Root Resection/ Removal	2930	Buried tooth roots, (includes more than one root) of one tooth, removal of	Yes	Side Room	For codes 2930 and 2935, the term "buried roots" refers to roots which are firmly invested in bone and require surgical removal of bone to effect their excision Benefit does not apply to superficial roots which can be removed with simple elevation Please note that the benefit in respect of the removal of impacted or buried teeth and roots includes the removal of the follicle or associated pathological tissue such as abscess, granulomatous and/ or cystic tissue
Root Resection/ Removal	2935	Buried tooth roots, (multiple) of teeth, removal of	Yes	Day Care	For codes 2930 and 2935, the term "buried roots" refers to roots which are firmly invested in bone and require surgical removal of bone to effect their excision Benefit does not apply to superficial roots which can be removed with simple elevation Please note that the benefit in respect of the removal of impacted or buried teeth and roots includes the removal of the follicle or associated pathological tissue such as abscess, granulomatous and/ or cystic tissue
Root Resection/ Removal	3005	Root resection or apicectomy, single, with or without cyst removal and apical curettage	No	Side Room	No preapproval required
Root Resection/ Removal	3010	Root resection or apicectomy, multiple, with or without cyst removal and apical curettage	No	Side Room	No preapproval required
Tooth Extraction	2950	Extraction of teeth (more than six permanent teeth) with or without alveolectomy	No	Side Room	No preapproval required
Tooth Extraction	994411	Extraction of more than 6 teeth with or without alveolectomy, in a patient 16 years or younger under general anaesthetic	No	Day Care	No preapproval required

DERMATOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Abscess	1560	Incision and drainage of pilonidal abscess	No		1 Night Only
Abscess	1663	Drainage of abscess or haematoma, (deep tissues) requiring general anaesthetic	No		
Bone Marrow	4281	Bone marrow aspiration	No	Diagnostic, Side Room	
Bone Marrow	4282	Bone marrow biopsy	No	Diagnostic, Side Room	
Bone Marrow	4286	Bone marrow harvesting (I.P.)	No	Independent Procedure	

DERMATOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Bone Marrow	4287	Bone marrow aspiration and biopsy	No	Diagnostic, Side Room	
Excisions	1550	Malignant melanoma, wide excisional biopsy	No	Side Room	A copy of the histology report for all claims for this procedure must be available for review on request
Excisions	1551	Malignant melanoma, wide excisional biopsy with flap or graft repair	No	Day Care	If grafting was performed, the donor site for grafting material must be specified on the claim form and a copy of the histology report for all claims for this procedure must be included with the claim
Excisions	1561	Pilonidal sinus or cyst, excision of	No	Day Care	
Excisions	1562	Pilonidal sinus, excision of, with rhomboid flap/ z-plasty for closure of large defect; multiple layer closure	No		1 Night Only
Excisions	1575	Basal cell carcinoma/ squamous cell carcinoma/ non melanoma - simple excision	No	Side Room	A copy of the histology report for all claims for this procedure must be included with the claim
Excisions	1576	Basal cell carcinoma/ squamous cell carcinoma/ non melanoma, excision and graft or local flap	No	Side Room	If grafting was performed, the donor site for grafting material must be specified on the claim form and a copy of the histology report for all claims for this procedure must be included with the claim For this procedure (code 1576), if an earlier excision or biopsy (code 1575 or 1509) was performed within 6 weeks and the histology report confirmed BCC or SCC, then this cod, 1576 may be claimed for the second procedure when repair is carried out in accordance with this codes description, with or without additional margin excision Please include a copy of the original histology report that confirmed the earlier diagnosis of BCC or SCC
Excisions	1591	Hydradenitis suppurativa, excision and suture	No	Side Room	
Excisions	1592	Hydradenitis suppurativa, excision and graft	No		
Excisions	1593	Hydradenitis suppurativa, extensive debridement	No	Day Care	
Excisions	4290	Chondroma, removal	No	Day Care	

DERMATOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Mohs Surgery	1599	Adjacent tissue transfer or rearrangement or full thickness graft, free (incl direct closure of donor site) associated with Mohs surgery, (e.g. Z-plasty, W-plasty, V-Y plasty, rotation flap, advancement flap, double pedicle flap), head, neck, all sizes (benefit shown is payable in full)	No	Side Room	If repair requiring adjacent tissue transfer or multi-layered closure (involving deeper layers in addition to epidermal and dermal closure, with or without undermining) is performed, use ONE of code 1597, 1598, 1599 or 1604 which is payable in full with the Mohs codes listed, In some cases the repair may be carried out by consultant Plastic Surgeon. If an In-patient stay is medically necessary for extensive repairs, this should be fully documented on the claim form. Each case will be assessed on an individual case basis. Conditions of payment for code 1581, 1582, 1583, 1584, 1596, 1597 and 1598: 1. Lesions located in anatomic areas with high risk of recurrence of tumour. These areas would include involvement of the face, especially around nose, eyes, mouth and central third of face), external ear and tragus, temple, scalp, mucosal lesions and nail bed and periungual areas; or 2. Areas of important tissue preservation, including the face, ears, hands, feet, perianal and genitals; or 3. Recurrent or incompletely excised malignant lesions, regardless of anatomic regions; or 4. Previously irradiated skin areas in any anatomic region; or 5. For exceptionally large (>/= 2cm in diameter) or rapidly growing lesions in any anatomic region; or 6. tumours with aggressive histological patterns: basal cell carcinoma (BCC) morpheaform (sclerosing), basosquamous (metatypical or keratinising), perineural or perivascular involvement, infiltrating tumours, multicentric tumours, contiguous tumours (i.e. BCC and SCC): squamous cell carcinomas (SCC) ranging from undifferentiated to poorly differentiated and SCCs that are adenoid (acantholytic), adenosquamous, desmoplastic, infiltrative, perineural, periadnexal or perivascular; or 7. Tumours will ill defined borders; or 8. SCC associated with high risk of metastasis, including those arising in the following; Bowens disease (SCC in-situ); discoid lupus erythematosus; chronic osteomyelitis; lichen sclerosis et atrophicus; thermal or radiation injury; chronic sinuses and ulcers; and adenoid type lesions 9. The consultant performing Mohs surgery - usually a consultant Dermatologist - must have a special interest in Mohs surgery as demonstrated by: (a) having completed a recognised fellowship training in Mohs surgery of a duration of at least one year in an approved training centre (b) providing Irish Life Health healthcare with a letter from the training programme director certifying that the consultant has practised Mohs surgery on a multitude of skin cancer types and achieved an in-depth experience in reconstruction such that the consultant can practise Mohs unsupervised (c) providing Irish Life Health healthcare with a training log of completed Mohs surgery cases validated by the training programme director - on request. If repair requiring adjacent tissue transfer or multi-layered closure (involving deeper layers in addition to epidermal and dermal closure, with or without undermining) is performed, use ONE of code 1597 or 1598, which is payable in full with the Mohs codes listed, In some cases the repair may be carried out by consultant Plastic Surgeon. If an In-patient stay is medically necessary for extensive repairs, this should be fully documented on the claim form. Each case will be assessed on an individual case basis.
Port Wine Stains	15871	Laser treatment to port wine stains only, one or more sessions - general anaesthesia	No	Day Care	Photographic evidence must be supplied on request
Wounds	1578	Wounds or ulcers requiring debridement when it is medically necessary to perform the procedure under general anaesthetic	No	Independent Procedure, Day Care, Service	
Wounds	1603	Wounds greater than 7.5cm in total length, suture or staple of lacerated or torn tissue, single or multi layered closure with or without irrigation or debridement (I.P.)	No	Independent Procedure, Side Room	For procedure code 1601, 1602, 1603, benefit includes wound closure by tissue adhesives (e.g. Two-cyanoacrylate) either singly or in combination with sutures or staples or in combination with adhesive strips. Wound closures utilising adhesive strips as the sole repair material may only be claimed under our out-patient products.

DERMATOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Wounds	1604	Adjacent tissue transfer/ rearrangement/ full thickness graft, free (incl direct closure of donor site) associated with Mohs surgery, (e.g. Z-plasty, W-plasty, V-Y plasty, rotation flap, advancement flap, double pedicle flap), non-head and neck, all sizes (benefit shown is payable in full)	No	Side Room	If repair requiring adjacent tissue transfer or multi-layered closure (involving deeper layers in addition to epidermal and dermal closure, with or without undermining) is performed, use ONE of code 1597, 1598, 1599 or 1604 which is payable in full with the Mohs codes listed, In some cases the repair may be carried out by consultant Plastic Surgeon. If an In-patient stay is medically necessary for extensive repairs, this should be fully documented on the claim form. Each case will be assessed on an individual case basis. Conditions of payment for code 1581, 1582, 1583, 1584, 1596, 1597 and 1598: 1. Lesions located in anatomic areas with high risk of recurrence of tumour. These areas would include involvement of the face, especially around nose, eyes, mouth and central third of face), external ear and tragus, temple, scalp, mucosal lesions and nail bed and periungual areas; or 2. Areas of important tissue preservation, including the face, ears, hands, feet, perianal and genitals; or 3. Recurrent or incompletely excised malignant lesions, regardless of anatomic regions; or 4. Previously irradiated skin areas in any anatomic region; or 5. For exceptionally large (>/= 2cm in diameter) or rapidly growing lesions in any anatomic region; or 6. tumours with aggressive histological patterns: basal cell carcinoma (BCC) morpheaform (sclerosing), basosquamous (metatypical or keratinising), perineural or perivascular involvement, infiltrating tumours, multicentric tumours, contiguous tumours (i.e. BCC and SCC): squamous cell carcinomas (SCC) ranging from undifferentiated to poorly differentiated and SCCs that are adenoid (acantholytic), adenosquamous, desmoplastic, infiltrative, perineural, periadnexal or perivascular; or 7. Tumours will ill defined borders; or 8. SCC associated with high risk of metastasis, including those arising in the following; Bowens disease (SCC in-situ); discoid lupus erythematosus; chronic osteomyelitis; lichen sclerosis et atrophicus; thermal or radiation injury; chronic sinuses and ulcers; and adenoid type lesions 9. The consultant performing Mohs surgery - usually a consultant Dermatologist - must have a special interest in Mohs surgery as demonstrated by: (a) having completed a recognised fellowship training in Mohs surgery of a duration of at least one year in an approved training centre (b) providing Irish Life Health healthcare with a letter from the training programme director certifying that the consultant has practised Mohs surgery on a multitude of skin cancer types and achieved an in-depth experience in reconstruction such that the consultant can practise Mohs unsupervised (c) providing Irish Life Health healthcare with a training log of completed Mohs surgery cases validated by the training programme director - on request. If repair requiring adjacent tissue transfer or multi-layered closure (involving deeper layers in addition to epidermal and dermal closure, with or without undermining) is performed, use ONE of code 1597 or 1598, which is payable in full with the Mohs codes listed, In some cases the repair may be carried out by consultant Plastic Surgeon. If an In-patient stay is medically necessary for extensive repairs, this should be fully documented on the claim form. Each case will be assessed on an individual case basis.
Wounds	1620	Complex wound(s) repair, (torn, crushed, deep) lacerations or avulsions requiring prolonged debridement and irrigation, extensive undermining and/or trimming of defect edges and multi-layered closure (involving deeper layers in addition to skin closure) with or without stents or retention sutures (I.P.)	No	Independent Procedure, Day Care	

EAR, NOSE & THROAT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Bronchoscopy	1994	Bronchoscopy; diagnostic, flexible with or without one of the following: (a) bronchoalveolar lavage, (b) cell washing or brushing, (c) bronchial biopsy (I.P.)	No	Independent Procedure, Diagnostic, Day Care	Where a code 2113 is performed on the same day and in a different physical location in the hospital with gap of 2 hours or more, then the payment indicator "Independent Procedure" will not apply for Consultant fees only.
Bronchoscopy	1999	Bronchoscopy with laser ablation/ resection of tumour (I.P.)	No	Independent Procedure	
Bronchoscopy	2004	Bronchoscopy with transbronchial biopsy of tumour(s), nodule(s) or lymph node(s) with or without fluoroscopic or endobronchial ultrasound (EBUS) guidance (includes washing or brushings, if performed) (I.P.)	No	Independent Procedure, Diagnostic, Day Care	

EAR, NOSE & THROAT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Bronchoscopy	2012	Bronchoscopy with or without bronchial biopsy (claimable for patients less than 2 years old) (I.P.)	No	Independent Procedure, Diagnostic	Benefit is claimable for patients less than 2 years old only
Bronchoscopy	2013	Bronchoscopy; rigid, under general anaesthetic (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Bronchoscopy	2014	Bronchoscopy and airway evaluation in patients with suspected (on the basis of severe sleep disturbance) or proven sleep apnoea (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Bronchoscopy	2020	Bronchoscopy with removal of foreign body (includes foreign body removal by rigid endoscopy) (I.P.)	No	Independent Procedure, Diagnostic	
Bronchoscopy	231652	Bronchoscopy, rigid or flexible including fluoroscopic guidance with EBUS (endobronchial ultrasound) guided transtracheal and/or transbronchial sampling from one or two mediastinal and/ or hilar lymph node stations or structures (I.P.)	No	Independent Procedure, Side Room	
Bronchoscopy	231653	Bronchoscopy, rigid or flexible including fluoroscopic guidance with EBUS (endobronchial ultrasound) guided transtracheal and/ or transbronchial sampling from three or more mediastinal and/ or hilar lymph node stations or structures (I.P.)	No	Independent Procedure, Side Room	
Bronchoscopy	941921	Combined bronchoscopy with laser ablation/ resection of tumour and full pulmonary function studies for the diagnosis and assessment of obstructive or restrictive lung disease (I.P.)	No	Independent Procedure, Diagnostic, Side Room	To be eligible for this benefit, the rules from codes 1999 & 2113 apply plus the procedures must be performed: (a) On the same day and (b) In the same approved Irish Life Health approved hospital and (c) By the same consultant
Ear	1665	Atresia of auricle, 2 or 3 stages, correction of (per stage) (I.P.)	No	Independent Procedure	
Ear	1666	Attico antrostomy, unilateral	No		
Ear	1670	Excision/ repair external ear; soft tissue lesion(s), polyp/ polyps or repair of split ear lobe(s) or other trauma, one or both ears	No	Side Room	
Ear	1671	Debridement of ear canal and microinspection of tympanic membrane unilateral or bilateral, requiring the use of an operating microscope and a hospital operating theatre e.g. in chronic otitis media or keratosis obturans (not for routine syringing, cleaning or the removal of impacted cerumen) (I.P.)	No	Independent Procedure, Side Room	
Ear	1672	Labyrinthotomy, with or without cryosurgery including other non excisional destructive procedures or perfusion of vestibuloactive drugs, single perfusion, transcanal	No	Side Room	
Ear	1675	Drainage external ear, abscess or haematoma	No	Day Care	
Ear	1680	External auditory canal, excision of tumour	No	Day Care	
Ear	1685	External auditory canal, removal of exostosis or osteoma	No		

EAR, NOSE & THROAT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Ear	1686	External auditory canal, reconstruction of (meatoplasty) (e.g. for stenosis due to trauma, infection) (I.P.)	No	Independent Procedure, Day Care	
Ear	1690	Facial nerve decompression (in temporal bone)	No		
Ear	1695	Facial nerve graft (in temporal bone)	No		
Ear	1700	Foreign body, removal from ear, under general anaesthetic (I.P.)	No	Independent Procedure, Day Care	
Ear	1701	Labyrinthectomy; transcanal	No		
Ear	1710	Mastoidectomy, radical with or without labyrinthectomy	No		
Ear	1715	Mastoidectomy, simple	No		
Ear	1730	Myringoplasty, surgery confined to drumhead and donor area (not for the removal of myringotomy tubes) (I.P.)	No	Independent Procedure, Day Care	
Ear	1735	Myringotomy, unilateral	No	Day Care	
Ear	1740	Myringotomy, bilateral	No	Day Care	
Ear	1741	Removal of drain tube(s) under general anaesthetic	No	Day Care	
Ear	1751	Pinna, total excision	No		
Ear	1752	Pinna, partial excision with flap reconstruction	No	Side Room	
Ear	1753	Pinna, partial excision and graft	No	Day Care	
Ear	1755	Preauricular sinus, excision of	No	Day Care	
Ear	1760	Saccus endolymphaticus for Meniere's Disease	No		
Ear	1770	Stapedectomy	No		
Ear	1771	Stapedectomy with plastic reconstruction of ossicles	No		
Ear	1785	Myringotomy with insertion of grommet	No	Day Care	
Ear	1786	Myringotomy, bilateral, with insertion of grommets	No	Day Care	
Ear	1788	Tympanic membrane repair, with or without site preparation or perforation for closure, with or without patch (not for the removal of myringotomy tubes) (I.P.)	No	Independent Procedure, Day Care	
Ear	1790	Tympanoplasty with elevation of tympanomeatal flap (I.P.)	No	Independent Procedure	1 Night Only
Ear	5980	Combined approach tympanoplasty (with mastoidotomy)	No		1 Night Only

EAR, NOSE & THROAT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Ear	309012	Debridement of post-mastoidectomy cavity and micro-inspection of tympanic membrane, unilateral and/ or bilateral, in a hospital theatre via microscope	No		
Ear	309021	Transcranial excision of glomus tympanicum tumour (I.P.)	No	Independent procedure	
Ear	309022	Transmastoid excision of glomus tympanicum tumour (I.P.)	No	Independent procedure	
Larynx	2030	Laryngoscopy, flexible/ rigid under topical anaesthesia (I.P.)	No	Independent Procedure, Diagnostic, Side Room	
Larynx	2031	Laryngoscopy, direct, operative with biopsy (I.P.)	No	Independent Procedure, Day Care	
Larynx	2032	Laryngoscopy, direct, with or without tracheostomy, with dilatation (I.P.)	No	Independent Procedure, Day Care	
Larynx	2040	Laryngectomy, all forms including vertical hemi-laryngectomy and tracheostomy	No		
Larynx	2050	Laryngofissure, external operation on	No		
Larynx	2051	Laryngoplasty, (type 1 thyroplasty) including transcervical placement of an implant (e.g. for burns, reconstruction after partial laryngectomy or post thyroid surgery	No		
Larynx	2053	Aryepiglottoplasty for the management of laryngomalacia in a multi-disciplinary team approach to care for a child under one year of age	No		
Larynx	2054	Microsurgery with CO2 laser for the complete removal of laryngeal cancer	No		
Larynx	2055	Lateral pharyngotomy	No		
Larynx	2056	Microsurgery of larynx with complete removal of benign or malignant lesions (not for biopsy of lesions - code 2031) (I.P.)	No	Independent Procedure, Day Care	
Larynx	2057	Vocal cord augmentation (injection of teflon)	No		
Larynx	2058	Botulinum toxin injections for laryngeal dysphonia	No	Side Room	
Nose and Accessory Sinuses	1745	Nostril closure, for atrophic rhinitis	No		
Nose and Accessory Sinuses	1805	Epistaxis - posterior packing and/ or cautery (I.P.)	No	Independent Procedure, Side Room	

EAR, NOSE & THROAT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Nose and Accessory Sinuses	1810	Epistaxis, anterior ethmoidal and/ or internal maxillary artery ligation (I.P.)	No	Independent Procedure	
Nose and Accessory Sinuses	1815	Foreign body, removal from nose, under general anaesthetic	No	Day Care	
Nose and Accessory Sinuses	1820	Polypectomy, single (I.P.)	No	Independent Procedure, Day Care	
Nose and Accessory Sinuses	1825	Polypectomy, multiple (I.P.)	No	Independent Procedure, Day Care	
Nose and Accessory Sinuses	1830	Accessory sinuses, open operations on, unilateral (including Caldwell Luc)	No		
Nose and Accessory Sinuses	1840	Accessory sinuses, open operations on, bilateral (including Caldwell Luc)	No		
Nose and Accessory Sinuses	1850	Antral biopsy	No	Diagnostic	
Nose and Accessory Sinuses	1855	Antral puncture (antrotomy) and washout unilateral (I.P.)	No	Independent Procedure, Side Room	
Nose and Accessory Sinuses	1860	Antral puncture (antrotomy) and washout bilateral (I.P.)	No	Independent Procedure, Day Care	
Nose and Accessory Sinuses	1875	Sinusotomy with or without biopsy, with mucosal stripping or removal of polyp(s)	No	Day Care	
Nose and Accessory Sinuses	1879	Nasal/ sinus endoscopy, surgical, with control of nasal haemorrhage, when medically necessary to perform under general anaesthetic (I.P.)	No	Independent Procedure, Day Care	
Nose and Accessory Sinuses	1880	Nasal/ sinus endoscopy, surgical, with antrostomy, unilateral	No	Day Care	
Nose and Accessory Sinuses	1885	Nasal/ sinus endoscopy, surgical, with antrostomy, bilateral	No	Day Care	
Nose and Accessory Sinuses	1890	Repair of choanal atresia, intranasal	No		
Nose and Accessory Sinuses	1895	Repair of choanal atresia, transpalatine	No		
Nose and Accessory Sinuses	1896	Crawford tube insertion, unilateral	No		
Nose and Accessory Sinuses	1897	Crawford tube insertion, bilateral	No		
Nose and Accessory Sinuses	1900	Ethmoid area, malignant tumour excision	No		

EAR, NOSE & THROAT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Nose and Accessory Sinuses	1905	Nasal/ sinus endoscopy, surgical with biopsy, polypectomy or removal of diseased mucosa, lesions or debridement (this code is not payable for planned routine follow-ups to any other ENT procedure e.g. for splint, removal, washout, healing check etc.) (I.P.)	No	Independent Procedure, Diagnostic, Side Room	
Nose and Accessory Sinuses	1910	Ethmoidectomy, extranasal, unilateral	No		
Nose and Accessory Sinuses	1915	Ethmoidectomy, extranasal, bilateral	No		
Nose and Accessory Sinuses	1920	Ethmoidectomy, intranasal, unilateral	No		1 Night Only
Nose and Accessory Sinuses	1925	Ethmoidectomy, intranasal, bilateral (includes code 1992)	No		1 Night Only Includes Code 1992
Nose and Accessory Sinuses	1935	External frontal sinus exploration	No		
Nose and Accessory Sinuses	1940	External frontal sinus operation for malignant disease	No		
Nose and Accessory Sinuses	1945	External rhinotomy (with drainage of ethmoid frontal, or maxillary sinuses)	No		
Nose and Accessory Sinuses	1968	Nasal septum, insertion of prosthetic button	No	Day Care	
Nose and Accessory Sinuses	1969	Plastic repair of nasal septum (complete procedure, includes the removal of splints, washouts. Procedure codes 1904 or 1905 are not payable at a subsequent session) (I.P.)	No	Independent Procedure	1 Night Only
Nose and Accessory Sinuses	1970	Nasal septum, submucous resection of	No		
Nose and Accessory Sinuses	1980	Naso pharyngeal tumour, excision of	No		
Nose and Accessory Sinuses	1985	Oro antral fistula, closure of by means of surgical advancement of mucoperiosteal flap (does not apply for simple suturing or closure of socket immediately following extraction e.g. tooth/ teeth) (I.P.)	No	Independent Procedure, Day Care	
Nose and Accessory Sinuses	1990	Cauterisation and/ or ablation, mucous of turbinates, unilateral or bilateral, any method, superficial (I.P.)	No	Independent Procedure, Day Care	
Nose and Accessory Sinuses	1992	Nasal/ sinus endoscopy, surgical with ethmoidectomy (partial or total) bilateral	No		1 Night Only, May not be charged in conjunction with code 1993
Nose and Accessory Sinuses	1993	Nasal/ sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus, including ethmoidectomy	No	Day Care	May not be charged in conjunction with code 1992
Nose and Accessory Sinuses	4525	Rhinoplasty (complete procedure, includes the removal of splints, washouts. Procedure codes 1904 or 1905 are not payable at a subsequent session) (I.P.)	No	Independent Procedure	1 Night Only

EAR, NOSE & THROAT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Nose and Accessory Sinuses	5975	Rhinoplasty, primary, including major septal repair (complete procedure, includes the removal of splints, washouts. Procedure codes 1904 or 1905 are not payable at a subsequent session) (I.P.)	No	Independent Procedure	1 Night Only
Nose and Accessory Sinuses	231260	Plastic repair of nasal septum (complete procedure, includes the removal of splints, washouts) with nasal/ sinus endoscopy and antrostomy (I.P.)	No	Independent Procedure	Procedure codes 1904 or 1905 are not payable at a subsequent session
Nose and Accessory Sinuses	304010	Surgical nasal/ sinus endoscopy with ethmoidectomy (partial or total), unilateral	No		1 Night Only
Oesophagus	2062	Oesophagoscopy, rigid under general anaesthesia, with or with out biopsy, with or with out dilatation (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Oesophagus	2063	Oesophagoscopy with radiofrequency ablation of Barrett's oesophagus with high grade dysplasia	No		
Oesophagus	2070	Oesophagoscopy with removal of foreign body (I.P.)	No	Independent Procedure	
Oesophagus	2074	Upper gastrointestinal endoscopy with oesophageal dilatation and laser therapy	No	Day Care	
Oesophagus	2079	Oesophagoscopy with multiple injection or banding of oesophageal varices	No	Day Care	
Oesophagus	2081	Balloon dilatation of the oesophagus (includes endoscopy)	No	Side Room	
Oesophagus	2132	Tracheoesophageal puncture and insertion of prosthesis	No		
Oesophagus	5840	Oesophageal motility (manometric) studies with or without 24 hour pH recording	No	Diagnostic, Side Room	
Oesophagus	5900	Cricopharyngeal myotomy (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Other ENT Procedures	2096	Drainage and marsupialisation of cyst	No	Day Care	
Other ENT Procedures	2116	Panendoscopy under general anaesthetic for patients with a biopsy-confirmed diagnosis of cancer to include oral cavity, oro-pharynx, naso-pharynx, hypo-pharynx and larynx, oesophagoscopy, with or without bronchoscopies, initial work-up prior to surgery, radiotherapy or both	No	Day Care	
Pharynx	1995	Abscess (retropharyngeal), incision and drainage (internal pharyngotomy)	No		
Pharynx	2085	Pharyngeal pouch or diverticulum, excision of	No		
Pharynx	2090	Pharyngeal pouch or diverticulum, endoscopic diathermy division	No		
Pharynx	2100	Pharyngolaryngectomy	No		
Pharynx	2115	Incision and drainage, abscess; retropharyngeal or parapharyngeal	No		
Tonsils	2125	Tonsils and/ or adenoids (adults), removal of	No		1 Night Only

EAR, NOSE & THROAT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Tonsils	2130	Tonsils and/ or adenoids (children under 12 years), removal of	No		1 Night Only
Tonsils	2131	Tonsils or tonsils and adenoids, secondary surgical intervention for the arrest of haemorrhage requiring general anaesthetic, following the first operation	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Abdominal Wall and Peritoneum	5	Abdominal wall, secondary suture of	No		
Abdominal Wall and Peritoneum	15	Adhesions, division of by laparotomy or laparoscopy (I.P.)	No	Independent Procedure	
Abdominal Wall and Peritoneum	20	Intra-abdominal injury with rupture of viscus, repair of (not including intraoperative injury) (I.P.)	No	Independent Procedure	
Abdominal Wall and Peritoneum	25	Intra abdominal injury, multiple complicated with rupture of viscus (I.P.)	No	Independent Procedure	
Abdominal Wall and Peritoneum	30	Laparotomy (I.P.)	No	Independent Procedure	
Abdominal Wall and Peritoneum	35	Laparoscopy with or without biopsy (I.P.)	No	Independent Procedure	1 Night Only
Abdominal Wall and Peritoneum	45	Omentopexy	No		
Abdominal Wall and Peritoneum	60	Pelvic abscess, drainage of	No		
Abdominal Wall and Peritoneum	80	Peritoneum, drainage of (I.P.)	No	Independent Procedure	
Abdominal Wall and Peritoneum	90	Laparotomy, intra-abdominal sepsis (I.P.)	No	Independent Procedure	
Abdominal Wall and Peritoneum	5835	Peritoneal, venous shunt for ascites	No		Possible co-payment please check Table of Cover
Adrenal Glands	95	Adrenalectomy, unilateral (I.P.)	No	Independent Procedure	
Adrenal Glands	101	Adrenalectomy for phaeochromocytoma	No		
Adrenal Glands	102	Laparoscopy, surgical with adrenalectomy, partial or complete or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal	No		
Adrenal Glands	106	Neuroblastoma, tru-cut biopsy	No	Diagnostic	
Adrenal Glands	107	Neuroblastoma, resection	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Appendix	110	Appendicectomy (with or without complications) (I.P.)	No	Independent Procedure	
Appendix	111	Appendicectomy, laparoscopic approach (with or without complications) (I.P.)	No	Independent Procedure	
Biliary System	115	Cholecystojejunostomy	No		
Biliary System	116	Choledochojejunostomy (Roux - En - Y)	No		
Biliary System	117	Choledochoduodenostomy	No		
Biliary System	118	Surgical repair of post-operative biliary stricture	No		
Biliary System	129	Hepaticojejunostomy	No		
Biliary System	132	Cholecystectomy with exploration of common bile duct	No		
Biliary System	135	Cholecystectomy including per operative cholangiogram	No		
Biliary System	136	Percutaneous removal of gallstones from the bile ducts	No		
Biliary System	140	Cholecystostomy with exploration, drainage or removal of calculus	No		
Biliary System	145	Hepaticoduodenostomy	No		
Biliary System	150	Trans-duodenal sphincteroplasty with or without transduodenal extraction of calculus	No		
Biliary System	151	Transhepatic insertion of biliary endoprosthesis or catheter for biliary drainage	No		
Biliary System	156	Revision and/ or reinsertion of transhepatic stent (I.P.)	No	Independent Procedure	
Biliary System	157	Change of percutaneous tube or drainage catheter, includes radiological guidance	No	Side Room, Sedation	
Biliary System	612	Portoenterostomy (e.g. Kasai procedure)	No		
Biliary System	456002	Day case laparoscopic cholecystectomy including pre-operative cholangiogram	No		Day Case
Biliary System	456003	In-patient laparoscopic cholecystectomy including pre-operative cholangiogram	No		1 Night Only
Breast	1190	Abscess, incision and drainage of	No	Side Room	
Breast	1195	Percutaneous core needle biopsy of breast with or without ultrasound guidance (for fine needle biopsy use procedure code 1191) (I.P.)	No	Independent Procedure, Diagnostic, Side Room	
Breast	1198	Re-excision of margins arising from previous breast surgery (I.P.)	No	Independent Procedure, Day Care	

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Breast	1200	Cysts or tumours, excision of, or lumpectomy, segmental resection, quadrant mastectomy or partial mastectomy	No	Day Care	
Breast	1205	Duct papilloma, excision of	No	Day Care	
Breast	1206	Mastectomy, partial, guided excision, with axillary sampling or removal of sentinel node(s) and immediate deep rotation flap reconstruction, with or without prosthetic implant	No		1 Night Only
Breast	1207	Skin sparing mastectomy with free skin and/ or muscle flap with microvascular anastomosis (I.P.)	No	Independent Procedure	
Breast	1208	Open periprosthetic capsulotomy breast (I.P.)	No	Independent Procedure	
Breast	1209	Periprosthetic capsulotomy breast (I.P.)	No	Independent Procedure	
Breast	1210	Gynaecomastia (excision for), unilateral	Yes	Day Care	Benefit for excision of gynaecomastia in accordance with procedure codes 1210 and 1211 is subject to pre-certification Gynaecomastia is defined as benign glandular breast enlargement due to ductal proliferation, stromal proliferation or both. The diagnosis must be based on both physical examination that confirms that the breast enlargement is true gynaecomastia and not pseudogynaecomastia, and laboratory, and other appropriate investigations as required should have been performed to identify any underlying reversible causes. Clinical Indications for procedure codes 1210, 1211 must be satisfied in full, included on the claim form for payment and are as follows: (a) Post-pubertal (b) BMI < 25 (c) Unilateral or bilateral gynaecomastia grade III or IV (Grade III gynaecomastia being moderate breast enlargement exceeding the areola boundaries with edges that are distinct from the chest with skin redundancy. Grade IV being gynaecomastia being marked breast enlargement with skin redundancy and feminisation of the breast) (d) Gynaecomastia that has been present for at least 1 year and has persisted despite treatment for at least 4 months for the underlying pathological cause (e) > / = 6 months pain or discomfort, directly attributable to breast hypertrophy, that is unresolved despite the continuous use for at least 4 weeks of prescription analgesia or non-steroidal anti-inflammatory drugs and significantly impacts on activities of daily living
Breast	1211	Gynaecomastia (excision for), bilateral	Yes		Benefit for excision of gynaecomastia in accordance with procedure codes 1210 and 1211 is subject to pre-certification Gynaecomastia is defined as benign glandular breast enlargement due to ductal proliferation, stromal proliferation or both. The diagnosis must be based on both physical examination that confirms that the breast enlargement is true gynaecomastia and not pseudogynaecomastia, and laboratory, and other appropriate investigations as required should have been performed to identify any underlying reversible causes. Clinical Indications for procedure codes 1210, 1211 must be satisfied in full, included on the claim form for payment and are as follows: (a) Post-pubertal (b) BMI < 25 (c) Unilateral or bilateral gynaecomastia grade III or IV (Grade III gynaecomastia being moderate breast enlargement exceeding the areola boundaries with edges that are distinct from the chest with skin redundancy. Grade IV being gynaecomastia being marked breast enlargement with skin redundancy and feminisation of the breast) (d) Gynaecomastia that has been present for at least 1 year and has persisted despite treatment for at least 4 months for the underlying pathological cause (e) > / = 6 months pain or discomfort, directly attributable to breast hypertrophy, that is unresolved despite the continuous use for at least 4 weeks of prescription analgesia or non-steroidal anti-inflammatory drugs and significantly impacts on activities of daily living
Breast	1212	Mastectomy, complete, with or without removal of sentinel node(s) and with or without immediate insertion of tissue expander, includes subsequent expansions (I.P.)	No	Independent Procedure	
Breast	1213	Mastectomy, partial, with or without guidance with axillary clearance, or removal of sentinel node(s)	No		1 Night Only
Breast	1214	Mastectomy, partial, guided excision, for ductal carcinoma insitu	No		1 Night Only
Breast	1216	Mastectomy radical/ modified radical, with axillary clearance	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Breast	1218	Mammographic wire guided excision breast biopsy	No	Diagnostic, Day Care	
Breast	1219	Mastectomy and axillary clearance, immediate breast reconstruction with latissimus dorsi pedicle flap, with or without prosthetic implant or expanding prosthesis	No		
Breast	1221	Mastectomy and axillary clearance, immediate breast reconstruction with extended latissimus dorsi pedicle flap	No		
Breast	1222	Mastectomy, complete with or without removal of sentinel node(s) with immediate insertion of tissue expander, includes subsequent expansions	No		
Breast	1223	Mastectomy, partial, guided excision, with axillary sampling or removal of sentinel node(s), with immediate deep rotation flap reconstruction, with prosthetic implant	No		
Breast	193001	Prophylactic unilateral mastectomy, without insertion of tissue expander	Yes		
Breast	193002	Prophylactic unilateral mastectomy, complete with immediate insertion of tissue expander and subsequent expansions	Yes		
Breast	193003	Prophylactic unilateral mastectomy, immediate breast reconstruction with latissimus dorsi pedicle flap, +/- prosthetic implant or expanding prosthesis	Yes		
Breast	193004	Prophylactic unilateral mastectomy, immediate breast reconstruction with extended latissimus dorsi pedicle flap	Yes		
Breast	193005	Prophylactic bilateral mastectomy, complete, without immediate insertion of tissue expander	Yes		
Breast	193006	Prophylactic bilateral mastectomy, complete, with immediate insertion of tissue expander, includes subsequent expansions	Yes		
Breast	193007	Prophylactic bilateral mastectomy, immediate breast reconstruction with latissimus dorsi pedicle flap, +/- prosthetic implant or expanding prosthesis	Yes		
Breast	193008	Prophylactic bilateral mastectomy, immediate breast reconstruction with extended latissimus dorsi pedicle flap	Yes		
Breast	441196	Skin sparing mastectomy (I.P.)	No	Independent Procedure	
Breast	1212R	Mastectomy, risk reducing prophylactic, complete, with or without immediate insertion of tissue expander, includes subsequent expansions (I.P.)	Yes	Independent Procedure	Cover must be requested in advance and only by way of the standard template available from Irish Life Health
Gastric	155	Antrectomy and drainage	No		
Gastric	165	Duodenal diverticula, excision of	No		
Gastric	174	Wedge gastric excision for ulcer or tumour of stomach	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Gastric	175	Gastrectomy, total or revision with anastomosis, pouch formation/ reconstruction/ Roux-en-Y reconstruction	No		
Gastric	180	Gastrectomy, partial with anastomosis, pouch formation/ reconstruction/Roux-en-Y reconstruction (Not Claimable for Morbid Obesity)	No		
Gastric	190	Gastroenterostomy	No		
Gastric	192	Capsule endoscopy	No	Diagnostic, Side Room, Monitored Anaesthesia Care	Clinical indications for procedure code 192 are as follows: one of which must be included on claim form for payment: (a) For evaluation of loco-regional carcinoid tumours of the small bowel in persons with carcinoid syndrome (b) For initial diagnosis in persons with suspected Crohn's disease (abdominal pain or diarrhoea plus one or more signs of inflammation (fever, elevated white blood cell count, elevated erythrocyte sedimentation rate, or bleeding) without evidence of disease on conventional diagnostic tests, including small-bowel follow-through or abdominal CT scan/ CT enterography and upper and lower endoscopy (c) For investigation of patients with objective evidence of recurrent, obscure gastro intestinal bleeding (e.g. iron deficiency anaemia and positive faecal occult blood test, or visible bleeding) who have had upper and lower gastrointestinal endoscopies within the last 12 months that have failed to identify a bleeding source (d) For surveillance of small intestinal tumours in persons with Lynch syndrome, Peutz-Jeghers syndrome and other polyposis syndromes affecting the small bowel

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Gastric	194	Upper gastrointestinal endoscopy with or without biopsies (includes jejunal biopsy), with or without polypectomy	No	Diagnostic, Side Room, Monitored Anaesthesia Care	Clinical indications for an initial upper G.I. endoscopy (excludes repeat procedures within 12 months, for which there are other specific clinical indications), one of which must be included on claim form for payment: (a) Upper abdominal symptoms that persist in patients that have been tested and received treatment for Helicobacter pylori and/ or been treated with a trial of PPI's for 6 weeks (b) Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease (i.e. anorexia and weight loss) or in patients > 45 years old (c) Dysphagia or odynophagia (d) Oesophageal reflux symptoms that are persistent or recurrent despite appropriate treatment (e) Persistent vomiting of unknown cause (f) Biopsy for suspected coeliac disease (g) Other diseases in which the presence of upper GI pathologic conditions might modify other planned management (h) Familial adenomatous polyposis syndromes (i) For confirmation and specific histologic diagnosis of radiological demonstrated lesions - suspected neoplastic lesion, gastric ulcer oseophageal ulcer, upper tract stricture or obstruction (j) Patients with active/ recent GI bleeding (k) Iron deficiency anaemia or chronic blood loss (l) Patients with suspected portal hypertension to document or treat oesophageal varices (m) To assess acute injury after caustic ingestion (n) Treatment of bleeding lesions such as ulcers, tumours, vascular abnormalities (e.g. electro-coagulation, heater probe, laser photocoagulation, or injection therapy) (o) banding or sclerotherapy of oesophageal varices (p) Removal of foreign body (q) Dilatation of stenotic lesions (r) Further investigation of suspected achalasia (s) Palliative treatment of stenosing neoplasms Clinical Indications for a repeat upper G.I. endoscopy - no consultant or hospital benefits are payable for a repeat upper G.I. endoscopy within a 12 month period except for the following clinical indications: (1) Histological diagnosis of gastric or oesophageal ulcer (2) Coeliac disease – re-check for healing 3 months (once only) (3) Achalasia (4) Post banding of oesophageal varices (5) Patients diagnosed with an atypical (non-H. pylori-associated) or high-risk duodenal ulcer - benefit will be provided for one repeat endoscopy to re-biopsy (except by report) (6) Stent blockage (7) Re-biopsy of an oesophageal ulcer (8) Barrett's mucosa with dysplasia (9) Gastric mucosa showing dysplasia (10) Follow up of patients post gastric or oesophageal cancer - benefit will be provided for endoscopies as clinically indicated. New clinical indications, unrelated to the indications for an earlier endoscopy, within the 12 month period, themselves an identified indication(s) for endoscopy, will not be excluded by a prior endoscopy. Please refer to the initial endoscopy codes.
Gastric	198	Upper gastrointestinal endoscopy including oesophagus, stomach and either the duodenum and/ or jejunum as appropriate, with endoscopic ultrasound examination	No	Diagnostic, Side Room, Sedation	Procedure code 198 is not payable in conjunction with procedure codes 194, 201, 202 or 271 Clinical indications for procedure code 198 are as follows: must be included on claim form for payment (a) Oesophageal cancer: pre-operative staging and assessment of the resectability in operable patients without distant metastases, especially when stage dependent treatment protocols are applied (b) Gastric carcinoma: pre-operative staging of gastric cancer in patients without distant metastases if the local stage has an impact on therapy (local resection, neoadjuvant chemotherapy) (c) Gastric (i) Gastrointestinal sub mucosal tumours to differentiate from extra luminal compression and to plan therapy (resection or follow-up) (ii) Gastric: For diagnosis of gastric malt lymphoma (d) Biliary tumours: pre-operative staging and distal bile duct tumours (e) Benign conditions of the biliary tract; microlithiasis associated with acute pancreatitis (f) Benign conditions of the biliary tract; microlithiasis associated with acute pancreatitis/ post-cholecystectomy patients presenting with suspected biliary colic and have normal abdominal ultrasound and normal liver function tests (g) Pancreatic tumours: staging (h) Neuroendocrine tumours: locating neuroendocrine tumours, including insulinomas and gastrinomas
Gastric	200	Gastrostomy	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Gastric	201	Insertion of percutaneous endoscopic gastrostomy (PEG) tube	No		
Gastric	202	Upper gastrointestinal endoscopy with endoscopic ultrasound exam including oesophagus, stomach and either the duodenum and/ or jejunum as appropriate with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/ biopsy(s) of lymph nodes in oesophageal, gastric and lung cancer, biopsy of pancreatic lesion(s), mediastinal mass or submucosal lesion(s), with or without coeliac plexus neurolysis for pain arising from pancreatic cancer or chronic pancreatitis	No	Diagnostic, Side Room	Procedure code 202 is not payable in conjunction with procedure codes 194, 198, 201 or 271 Clinical indications for an initial upper G.I. endoscopy (excludes repeat procedures within 12 months, for which there are other specific clinical indications), one of which must be included on claim form for payment: (a) Upper abdominal symptoms that persist in patients that have been tested and received treatment for Helicobacter pylori and/ or been treated with a trial of PPI's for 6 weeks (b) Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease (i.e. anorexia and weight loss) or in patients > 45 years old (c) Dysphagia or odynophagia (d) Oesophageal reflux symptoms that are persistent or recurrent despite appropriate treatment (e) Persistent vomiting of unknown cause (f) Biopsy for suspected coeliac disease (g) Other diseases in which the presence of upper GI pathologic conditions might modify other planned management (h) Familial adenomatous polyposis syndromes (i) For confirmation and specific histologic diagnosis of radiological demonstrated lesions - suspected neoplastic lesion, gastric ulcer oesophageal ulcer, upper tract stricture or obstruction (j) Patients with active/ recent GI bleeding (k) Iron deficiency anaemia or chronic blood loss (l) Patients with suspected portal hypertension to document or treat oesophageal varices (m) To assess acute injury after caustic ingestion (n) Treatment of bleeding lesions such as ulcers, tumours, vascular abnormalities (e.g. electro-coagulation, heater probe, laser photocoagulation, or injection therapy) (o) Banding or sclerotherapy of oesophageal varices (p) Removal of foreign body (q) Dilatation of stenotic lesions (r) Further investigation of suspected achalasia (s) Palliative treatment of stenosing neoplasms Clinical Indications for a repeat upper G.I. endoscopy - no consultant or hospital benefits are payable for a repeat upper G.I. endoscopy within a 12 month period except for the following clinical indications: (1) Histological diagnosis of gastric or oesophageal ulcer (2) Coeliac disease – re-check for healing 3 months (once only) (3) Achalasia (4) Post banding of oesophageal varices (5) Patients diagnosed with an atypical (non-H. pylori-associated) or high-risk duodenal ulcer - benefit will be provided for one repeat endoscopy to re-biopsy (except by report) (6) Stent blockage (7) Re-biopsy of an oesophageal ulcer (8) Barrett's mucosa with dysplasia (9) Gastric mucosa showing dysplasia (10) Follow up of patients post gastric or oesophageal cancer - benefit will be provided for endoscopies as clinically indicated. New clinical indications, unrelated to the indications for an earlier endoscopy, within the 12 month period, themselves an identified indication(s) for endoscopy, will not be excluded by a prior endoscopy. Please refer to the initial endoscopy codes.

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Gastric	203	Upper gastrointestinal endoscopy with transendoscopic stent placement (includes pre and post dilation) in patients with obstructing lesions or strictures	No	Independent Procedure, Diagnostic, Side Room	Clinical indications for an initial upper G.I. endoscopy (excludes repeat procedures within 12 months, for which there are other specific clinical indications), one of which must be included on claim form for payment: (a) Upper abdominal symptoms that persist in patients that have been tested and received treatment for Helicobacter pylori and/ or been treated with a trial of PPI's for 6 weeks (b) Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease (i.e. anorexia and weight loss) or in patients > 45 years old (c) Dysphagia or odynophagia (d) Oesophageal reflux symptoms that are persistent or recurrent despite appropriate treatment (e) Persistent vomiting of unknown cause (f) Biopsy for suspected coeliac disease (g) Other diseases in which the presence of upper GI pathologic conditions might modify other planned management (h) Familial adenomatous polyposis syndromes (i) For confirmation and specific histologic diagnosis of radiological demonstrated lesions - suspected neoplastic lesion, gastric ulcer oesophageal ulcer, upper tract stricture or obstruction (j) Patients with active/ recent GI bleeding (k) Iron deficiency anaemia or chronic blood loss (l) Patients with suspected portal hypertension to document or treat oesophageal varices (m) To assess acute injury after caustic ingestion (n) Treatment of bleeding lesions such as ulcers, tumours, vascular abnormalities (e.g. electro-coagulation, heater probe, laser photocoagulation, or injection therapy) (o) banding or sclerotherapy of oesophageal varices (p) Removal of foreign body (q) Dilatation of stenotic lesions (r) Further investigation of suspected achalasia (s) Palliative treatment of stenosing neoplasms Clinical Indications for a repeat upper G.I. endoscopy - no consultant or hospital benefits are payable for a repeat upper G.I. endoscopy within a 12 month period except for the following clinical indications: (1) Histological diagnosis of gastric or oesophageal ulcer (2) Coeliac disease – re-check for healing 3 months (once only) (3) Achalasia (4) Post banding of oesophageal varices (5) Patients diagnosed with an atypical (non-H. pylori-associated) or high-risk duodenal ulcer - benefit will be provided for one repeat endoscopy to re-biopsy (except by report) (6) Stent blockage (7) Re-biopsy of an oesophageal ulcer (8) Barrett's mucosa with dysplasia (9) Gastric mucosa showing dysplasia (10) Follow up of patients post gastric or oesophageal cancer - benefit will be provided for endoscopies as clinically indicated. New clinical indications, unrelated to the indications for an earlier endoscopy, within the 12 month period, themselves an identified indication(s) for endoscopy, will not be excluded by a prior endoscopy. Please refer to the initial endoscopy codes.
Gastric	204	Gastric antral vascular ectasia, endoscopic argon plasma photocoagulation of	No	Side Room, Sedation	
Gastric	205	Gastrostomy/ duodenotomy for haemorrhage	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Gastric	206	Upper gastrointestinal endoscopy with endoscopic mucosal resection	No	Diagnostic, Side Room, Sedation	Clinical indications for an initial upper G.I. endoscopy (excludes repeat procedures within 12 months, for which there are other specific clinical indications), one of which must be included on claim form for payment: (a) Upper abdominal symptoms that persist in patients that have been tested and received treatment for Helicobacter pylori and/ or been treated with a trial of PPI's for 6 weeks (b) Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease (i.e. anorexia and weight loss) or in patients > 45 years old (c) Dysphagia or odynophagia (d) Oesophageal reflux symptoms that are persistent or recurrent despite appropriate treatment (e) Persistent vomiting of unknown cause (f) Biopsy for suspected coeliac disease (g) Other diseases in which the presence of upper GI pathologic conditions might modify other planned management (h) Familial adenomatous polyposis syndromes (i) For confirmation and specific histologic diagnosis of radiological demonstrated lesions - suspected neoplastic lesion, gastric ulcer oesophageal ulcer, upper tract stricture or obstruction (j) Patients with active/ recent GI bleeding (k) Iron deficiency anaemia or chronic blood loss (l) Patients with suspected portal hypertension to document or treat oesophageal varices (m) To assess acute injury after caustic ingestion (n) Treatment of bleeding lesions such as ulcers, tumours, vascular abnormalities (e.g. electro-coagulation, heater probe, laser photocoagulation, or injection therapy) (o) banding or sclerotherapy of oesophageal varices (p) Removal of foreign body (q) Dilatation of stenotic lesions (r) Further investigation of suspected achalasia (s) Palliative treatment of stenosing neoplasms Clinical Indications for a repeat upper G.I. endoscopy - no consultant or hospital benefits are payable for a repeat upper G.I. endoscopy within a 12 month period except for the following clinical indications: (1) Histological diagnosis of gastric or oesophageal ulcer (2) Coeliac disease – re-check for healing 3 months (once only) (3) Achalasia (4) Post banding of oesophageal varices (5) Patients diagnosed with an atypical (non-H. pylori-associated) or high-risk duodenal ulcer - benefit will be provided for one repeat endoscopy to re-biopsy (except by report) (6) Stent blockage (7) Re-biopsy of an oesophageal ulcer (8) Barrett's mucosa with dysplasia (9) Gastric mucosa showing dysplasia (10) Follow up of patients post gastric or oesophageal cancer - benefit will be provided for endoscopies as clinically indicated. New clinical indications, unrelated to the indications for an earlier endoscopy, within the 12 month period, themselves an identified indication(s) for endoscopy, will not be excluded by a prior endoscopy. Please refer to the initial endoscopy codes.
Gastric	215	Over sewing perforated peptic ulcer	No		
Gastric	230	Ramstedt's operation	No		
Gastric	235	Stomach transection	No		
Head & Neck	1041	Excision of carotid body tumour greater than 4 cms	No		
Head & Neck	1042	Excision of carotid body tumour less than 4 cms	No		
Head & Neck	1046	Excision of lesion of mucosa and submucosa, vestibule of mouth, with simple repair (I.P.)	No	Independent Procedure, Side Room	Vestibule is considered to be the part of the oral cavity outside the dentoalveolar structure; it includes the mucosal and submucosal tissues of lips and cheeks
Head & Neck	1047	Excision of lesion of mucosa and submucosa, vestibule of mouth, complex, with or without excision of underlying muscle (I.P.)	No	Independent Procedure, Day Care	Vestibule is considered to be the part of the oral cavity outside the dentoalveolar structure; it includes the mucosal and submucosal tissues of lips and cheeks

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Head & Neck	1048	Excision of malignant growth of mucosa and submucosa, vestibule of mouth, wide excision with excision of underlying muscle, complex layered closure, with or without skin graft (I.P.)	No	Independent Procedure	Vestibule is considered to be the part of the oral cavity outside the dentoalveolar structure; it includes the mucosal and submucosal tissues of lips and cheeks
Head & Neck	1055	Cyst or benign tumour on lip, excision of (I.P.)	No	Independent Procedure, Side Room	
Head & Neck	1058	Epithelioma of lip, lip shave	No	Side Room	
Head & Neck	1059	Epithelioma of lip, wedge excision	No	Day Care	
Head & Neck	1065	Branchial cyst, pouch or fistula, excision of	No		
Head & Neck	1075	Cysts or tuberculosis glands of neck (deep to deep fascia) excision of	No	Day Care	
Head & Neck	1080	Conservative neck dissection	No		
Head & Neck	1082	Radical neck dissection	No		
Head & Neck	1085	Thyroglossal cyst or fistula, excision of	No		
Head & Neck	1090	Torticollis, partial excision, open correction of	No		
Head & Neck	1095	Tuberculous caseous glands or sinuses, curettage of	No		
Head & Neck	1096	Oesophageal anastomosis, (repair and short circuit)	No		
Head & Neck	1097	Partial oesophagectomy	No		
Head & Neck	1098	Gastrointestinal reconstruction for previous oesophagectomy, for obstructing oesophageal lesion or fistula, or for previous oesophageal exclusion with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	No		
Head & Neck	1100	Laceration of palate, repair of	No		
Head & Neck	1104	Biopsy lesion of palate	No	Side Room	
Head & Neck	1105	Radical operation for malignant growth of palate	No		
Head & Neck	1106	Partial maxillectomy including plastic reconstruction	No		
Head & Neck	1107	Total maxillectomy including plastic reconstruction	No		
Hernia	241	Laparoscopic, surgical repair, epigastric/ ventral hernia (includes mesh insertion) initial or recurrent (I.P.)	No	Independent Procedure	
Hernia	243	Laparoscopic surgical repair, epigastric/ ventral hernia (initial or recurrent) (I.P.)	No	Independent Procedure	1 Night Only
Hernia	244	Laparoscopic surgical repair, epigastric/ ventral hernia; incarcerated or strangulated (I.P.)	No	Independent Procedure	
Hernia	245	Epigastric/ ventral hernia, repair of (I.P.)	No	Independent Procedure	1 Night Only
Hernia	246	Exomphalos, minor	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Hernia	247	Exomphalos, major	No		
Hernia	248	Exomphalos, delayed	No		
Hernia	249	Laparoscopic, surgical repair, epigastric/ ventral hernia (includes mesh insertion) incarcerated or strangulated (I.P.)	No	Independent Procedure	
Hernia	250	Femoral hernia, repair of, bilateral	No		
Hernia	255	Femoral hernia, repair of, unilateral (I.P.)	No	Independent Procedure	1 Night Only
Hernia	270	Hiatus hernia, abdominal repair of	No		
Hernia	271	Laparoscopic repair of hiatus hernia	No		Clinical Indications for procedure code 271 are as follows: (a) Patients with a diagnosis of gastro-oesophageal reflex disease confirmed by both (i) Gastroscopy with photographic evidence of oesophagitis and 24 hour monitoring positive for reflux, i.e. identifying (1) a pH of less than 4 or greater than 5% of the day (2) a de Meester score greater than 15 (ii) Failure to respond to at least 8 weeks of treatment with proton pump inhibitors Code 271 is not claimable in conjunction with procedure codes 194, 590 or 5917
Hernia	272	Laparoscopic repair of paraoesophageal hernia, including fundoplasty (I.P.)	No	Independent Procedure	
Hernia	275	Hiatus hernia, transthoracic, repair of (I.P.)	No	Independent Procedure	
Hernia	276	Laparoscopic surgical repair of incisional hernia (includes mesh insertion) (initial or recurrent) (I.P.)	No	Independent Procedure	
Hernia	277	Laparoscopic surgical repair of incisional hernia (includes mesh insertion), incarcerated or strangulated (I.P.)	No	Independent Procedure	
Hernia	278	Laparoscopic surgical repair of incisional hernia, initial or recurrent (I.P.)	No	Independent Procedure	
Hernia	279	Laparoscopic surgical repair of incisional hernia, incarcerated or strangulated (I.P.)	No	Independent Procedure	
Hernia	280	Incisional hernia, repair of (I.P.)	No	Independent Procedure	
Hernia	283	Inguinal hernia, neonate up to six weeks of age, laparoscopic repair of, unilateral (I.P.)	No	Independent Procedure	
Hernia	284	Inguinal hernia, laparoscopic repair of, bilateral (I.P.)	No	Independent Procedure	1 Night Only
Hernia	285	Inguinal hernia, repair of, bilateral (I.P.)	No	Independent Procedure	1 Night Only
Hernia	286	Inguinal hernia, neonate up to six weeks of age, laparoscopic repair of, bilateral (I.P.)	No	Independent Procedure	
Hernia	287	Inguinal hernia, laparoscopic repair of, unilateral (I.P.)	No	Independent Procedure	1 Night Only
Hernia	288	Strangulated inguinal hernia, laparoscopic repair of, unilateral (I.P.)	No	Independent Procedure	

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Hernia	289	Repair of inguinal hernia, neonate up to six weeks of age, bilateral (I.P.)	No	Independent Procedure	
Hernia	290	Inguinal hernia, repair of, unilateral (I.P.)	No	Independent Procedure	1 Night Only
Hernia	291	Strangulated inguinal hernia, unilateral (I.P.)	No	Independent Procedure	
Hernia	292	Repair of inguinal hernia, neonate up to six weeks of age, unilateral (I.P.)	No	Independent Procedure	
Hernia	295	Patent urachus, closure and repair of abdominal muscles	No		
Hernia	305	Recurrent hernia, repair of (I.P.)	No	Independent Procedure	1 Night Only
Hernia	310	Umbilical hernia, repair of (I.P.)	No	Independent Procedure	1 Night Only
Hernia	443111	Repair laparoscopically of para-oesophageal hernia, including fundoplasty and mesh insertion (I.P.)	No	Independent procedure	
Jejunum & Ileum	320	Congenital defects, correction of (including Meckel's diverticulum)	No		
Jejunum & Ileum	331	Gastroschisis	No		
Jejunum & Ileum	355	Ileostomy or laparoscopic loop ileostomy (I.P.)	No	Independent Procedure	
Jejunum & Ileum	356	Ileoscopy, through stoma, with or without biopsy	No	Diagnostic, Side Room, Monitored Anaesthesia Care	
Jejunum & Ileum	360	Resection of small intestine; single resection and anastomosis (I.P.)	No	Independent Procedure	
Jejunum & Ileum	361	Intestinal atresia, single/ multiple	No		
Jejunum & Ileum	362	Intestinal stricturalplasty (enterotomy & enterorrahaphy) with or without dilation, for intestinal obstruction	No		
Jejunum & Ileum	363	Intestinal stricturoplasty (enterotomy & enterorrahaphy) with or without dilation, for intestinal obstruction, multiple, 3 or more	No		
Jejunum & Ileum	364	Hydrostatic reduction of intussusception	No		
Jejunum & Ileum	370	Jejunostomy	No		
Jejunum & Ileum	384	Laparoscopic resection and anastomosis of jejunum or ileum	No		
Jejunum & Ileum	385	Resection and anastomosis of jejunum or ileum	No		
Jejunum & Ileum	386	Surgical reduction of intussusception including repair with or without appendicectomy	No		
Large Intestine	389	Anal canal examination under anaesthesia (EUA) (I.P.)	No	Independent Procedure, Day Care	

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	390	Anal canal, plastic repair of (for incontinence)	No		
Large Intestine	391	Laparoscopic, low anterior/ abdomino-perineal resection with colo-anal anastomosis	No		
Large Intestine	392	Laparoscopic, mid/ high anterior resection with colo-anal anastomosis	No		
Large Intestine	395	Anal fissure, dilatation of anus (I.P.)	No	Independent Procedure, Day Care	
Large Intestine	396	Anoplasty for low anorectal anomaly	No		
Large Intestine	397	Anorectal anomaly, posterior sagittal anorectoplasty (PSARP), for high/ intermediate anorectal anomaly	No		
Large Intestine	400	Lateral internal sphincterotomy (I.P.)	No	Independent Procedure, Day Care	
Large Intestine	401	Botulinum toxin injection of anal sphincter under general anaesthetic	No	Day Care	
Large Intestine	404	Parks' anal sphincter repair	No		
Large Intestine	410	Anus, excision of epithelioma of, with colostomy	No	Day Care	
Large Intestine	415	Anus, excision of epithelioma of, without colostomy	No	Day Care	
Large Intestine	420	Caecostomy (I.P.)	No	Independent Procedure	
Large Intestine	425	Caecostomy or colostomy, closure of	No		
Large Intestine	430	Colectomy, partial	No		
Large Intestine	431	Laparoscopic colectomy, partial	No		
Large Intestine	432	Laparoscopic colectomy, total	No		
Large Intestine	433	Laparoscopic colectomy, total with ileal pouch reconstruction	No		
Large Intestine	434	Laparoscopic surgical closure of enterostomy, large or small intestine, with resection and anastomosis	No		
Large Intestine	435	Colectomy, total	No		
Large Intestine	436	Total colectomy and ileal pouch construction with temporary ileostomy	No		
Large Intestine	437	Closure of ileostomy	No		
Large Intestine	438	Total colectomy for toxic megacolon	No		
Large Intestine	439	Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and urethral transplantations, and/ or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(ies), or any combination thereof	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	448	Double balloon enteroscopy (antegrade or retrograde)	No	Diagnostic, Day Care, Sedation	Clinical Indications for procedure code 448 are as follows: (a) For investigating suspected small intestinal bleeding in persons with objective evidence of recurrent, obscure gastrointestinal bleeding (e.g. iron-deficiency anaemia, positive faecal occult blood test, or visible bleeding) who have had upper and lower gastrointestinal endoscopies that have failed to identify a bleeding source (b) For initial diagnosis in persons with suspected Crohn's disease (abdominal pain, diarrhoea, elevated ESR, elevated white cell count, fever, gastrointestinal bleeding, or weight loss) without evidence of disease on conventional diagnostic tests, including small bowel follow through and upper and lower endoscopy (c) For treating members with gastrointestinal bleeding when the small intestine has been identified as the source of bleeding
Large Intestine	449	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen by brushing or washing, with or without biopsy, single or multiple	No	Day Care	
Large Intestine	450	Colonoscopy, left side	No	Diagnostic, Side Room, Sedation	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis coli (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	454	Incomplete colonoscopy, claimable where the scope reached beyond the splenic flexure but where it was not possible to reach the caecum because of obstruction or lesion (for colonoscopy to the splenic flexure please use code 450)	No	Diagnostic, Side Room, Sedation	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis coli (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	455	Colonoscopy, full colon	No	Diagnostic, Side Room, Sedation	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis coli (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	456	Colonoscopy, left side, plus polypectomy	No	Diagnostic, Side Room, Sedation	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis coli (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	457	Colonoscopy plus polypectomy, full colon	No	Diagnostic, Side Room, Sedation	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis coli (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	458	Left colonoscopy and laser photocoagulation of rectum	No	Diagnostic, Side Room, Sedation	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis coli (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	459	Colonoscopy, full colon and laser photocoagulation of rectum	No	Diagnostic, Side Room, Sedation	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis coli (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals
Large Intestine	460	Colostomy (I.P.)	No	Independent Procedure	
Large Intestine	461	Reduction of prolapsed colostomy stoma	No		
Large Intestine	465	Resection of bowel and colostomy or anastomosis for diverticulitis	No		
Large Intestine	466	Endoscopic transanal resection of large (> 2cm) villous adenomas/ malignant tumours of rectum (ETART), using resectoscope	No		
Large Intestine	467	Colonoscopy with transendoscopic stent placement (includes pre dilation)	No		
Large Intestine	468	Excision of rectal tumour, transanal approach	No		
Large Intestine	470	Faecal fistula, closure or resection	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	485	Anal fistulotomy (I.P.)	No	Independent Procedure, Day Care	
Large Intestine	486	Fistula-in-ano, excision with endo-anal flap and advancement (I.P.)	No	Independent Procedure	
Large Intestine	487	Fistula-in-ano, insertion/ change of seton (I.P.)	No	Independent Procedure, Day Care	
Large Intestine	490	Haemorrhoidectomy (external) (I.P.)	No	Independent Procedure, Day Care	
Large Intestine	495	Haemorrhoidectomy, external, multiple (I.P.)	No	Independent Procedure, Day Care	
Large Intestine	500	Haemorrhoidectomy (internal) includes exploration of anal canal (I.P.)	No	Independent Procedure	
Large Intestine	501	Haemorrhoidopexy (e.g. for prolapsing internal haemorrhoids) by stapling	No		1 Night Only
Large Intestine	513	Meconium ileus, open reduction with or without stoma	No		
Large Intestine	514	Meconium ileus reduction	No		
Large Intestine	515	Imperforate anus, simple incision	No		
Large Intestine	516	Necrotising enterocolitis, percutaneous drainage	No		
Large Intestine	517	Necrotising enterocolitis, laparotomy resection/ stoma	No		
Large Intestine	518	Panproctocolectomy	No		
Large Intestine	520	Imperforate anus, with colostomy or pull through operation	No		
Large Intestine	525	Ischio rectal abscess, incision and drainage (I.P.)	No	Independent Procedure	1 Night Only

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	530	Proctoscopy or sigmoidoscopy (I.P.)	No	Independent Procedure, Diagnostic, Side Room, Sedation	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis coli (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	535	Proctoscopy or sigmoidoscopy, with biopsy (I.P.)	No	Independent Procedure, Diagnostic, Side Room, Sedation	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis coli (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	536	Diagnostic flexible sigmoidoscopy and biopsies (I.P.)	No	Independent Procedure, Diagnostic, Side Room, Sedation	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis coli (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	540	Proctoscopy or sigmoidoscopy with biopsy of muscle coats of bowel, for megacolon	No	Diagnostic, Day Care	Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (a) Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination Repeat colonoscopy, proctoscopy or sigmoidoscopy - clinical indications are as follows: (b) No consultant or hospital benefits are payable for repeat colonoscopic, proctoscopic or sigmoidoscopic examinations within 36 months of the initial examination except for the following clinical indications: (i) Following removal of adenomas with dysplasia (ii) Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session (iii) Pre-operative assessment of chronic inflammatory bowel disease (IBD) (iv) Relapse of IBD following change of therapy - post-colonic cancer surgery at 1, 3 and 5 years (v) In Crohns disease, post resection, assessment of surgical anastomosis after 6 months (vi) Cancer surveillance in chronic pan ulcerative colitis (vii) Where the patient's presenting symptoms indicate that a one sided colonoscopy is necessary and where the findings from that procedure suggest the possibility of disease elsewhere in the colon necessitating complete colon examination. The findings are as follows: (1) Colonic polyps (2) Colonic carcinoma (3) Inflammatory bowel disease (4) Blood stained mucus or stool coming from beyond the range of a left sided colon examination (viii) Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy (ix) Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication (x) Left colonoscopy at the time of significant symptomatic relapse (xi) Left colonoscopy where there is a failure to respond to treatment or where there is suspicion of a second diagnosis such as clostridium difficile infection with superimposed pseudo membranous colitis (xii) Evaluation of an abdominal mass (c) New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy (d) When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable (e) Clinical indications for which ILH pay for surveillance colonoscopy: (i) Individuals who have two first degree relatives diagnosed with colorectal cancer (ii) Individuals with a family history of polyposis coli (iii) Individuals with a family history of hereditary non-polyposis col (iv) Individuals who have a first degree relative who developed colorectal cancer before the age of sixty years will be entitled to benefit for colonoscopy every five years, beginning at age forty years or ten years before the age of the youngest affected relative, whichever is the first For indications (e)(i) to (e)(iv) ILH will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals
Large Intestine	545	Prolapse of rectum, abdominal approach involving laparotomy, colostomy or intestinal anastomosis including laparoscopic approach	No		
Large Intestine	549	Delorme procedure	No		
Large Intestine	550	Prolapse of rectum, perineal repair (I.P.)	No	Independent Procedure	
Large Intestine	555	Closure of rectovesical fistula, with or without colostomy (I.P.)	No	Independent Procedure	
Large Intestine	556	Balloon dilation of the rectum	No	Day Care	
Large Intestine	560	Rectal or sigmoid polyps (removal by diathermy etc.)	No	Day Care	
Large Intestine	565	Rectum, excision of (all forms including perineoabdominal, perineal anterior resection and laparoscopic approach)	No		
Large Intestine	570	Rectum, partial excision of	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Large Intestine	574	Presacral teratoma, excision of	No		
Large Intestine	576	Revision/ refashioning of ileostomy and duodenostomy, complicated reconstruction in-depth (I.P.)	No	Independent Procedure	
Large Intestine	577	Low anterior resection with colo-anal anastomosis for cancer	No		
Large Intestine	578	Soave procedure	No		
Large Intestine	579	Internal sphincter myomectomy in children with Hirschsprung disease	No		
Large Intestine	581	Sigmoidoscopy including dilatation of intestinal strictures	No	Day Care	
Large Intestine	582	Proctectomy for recurrent rectal cancer in a radiated and previously operated pelvis	No		
Large Intestine	585	Stricture of rectum (dilation of) (I.P.)	No	Independent Procedure, Day Care	
Large Intestine	590	Volvulus (stomach, small bowel or colon, including resection and anastomosis)	No		
Large Intestine	591	Correction of malrotation by lysis of duodenal bands and/ or resection of midgut volvulus (e.g. Ladd procedure)	No		
Large Intestine	5793	Percutaneous implantation of neurostimulator pulse generator and electrodes: faecal incontinence: trial stage	Yes		1 Night Only
Large Intestine	5794	Percutaneous implantation of neurostimulator electrodes for faecal incontinence; permanent implantation	No		2 Nights Only
Large Intestine	442110	Prophylactic total colectomy	Yes		
Large Intestine	442112	Prophylactic laparoscopic total colectomy	Yes		
Liver	595	Hepatotomy for drainage of abscess or cyst, one or two stages	No		
Liver	600	Biopsy of liver (by laparotomy) (I.P.)	No	Independent Procedure, Diagnostic	
Liver	601	Transjugular liver biopsy	No	Diagnostic	
Liver	605	Biopsy of liver (needle)	No	Diagnostic	1 Night Only
Liver	608	Management of liver haemorrhage; simple suture of liver wound or injury	No		
Liver	611	Major liver resection (I.P.)	No	Independent Procedure	
Liver	616	Wedge resection of liver	No		
Liver	617	Intrahepatic cholangioenteric anastomosis	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Liver	618	Resection of hilar bile duct tumour (I.P.)	No	Independent Procedure	
Liver	619	Management of liver haemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/ or suture, with or without packing of liver	No		
Liver	622	Insertion of hepatic artery catheter and reservoir pump	No		
Liver	625	Liver, left lateral lobectomy	No		
Liver	626	Intra-operative radiofrequency ablation of liver metastases	No		
Liver	630	Excision of hydatid cyst	No		
Lymphatics	1310	Open superficial lymph node biopsy	No	Day Care	
Lymphatics	1314	Sentinel node biopsy with injection of dye and identification	No	Day Care	
Lymphatics	1315	Axillary lymph nodes, complete dissection of	No		
Lymphatics	1320	Axillary or inguinal lymph nodes, incision of abscess	No	Side Room	
Lymphatics	1326	Biopsy or excision of lymph node(s); open, deep cervical or axillary node(s)	No	Diagnostic, Day Care	
Lymphatics	1335	Inguinal or pelvic lymph node block dissection, unilateral (I.P.)	No	Independent Procedure	
Lymphatics	1336	Inguinal or pelvic lymph node block dissection, bilateral (I.P.)	No	Independent Procedure	
Lymphatics	1365	Primary or secondary retroperitoneal, lymphadenectomy complete, transabdominal (I.P.)	No	Independent Procedure	

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Metabolic Surgery	493201	Metabolic surgery - gastric restrictive procedure with gastric by-pass with Roux-En-Y gastroenterostomy (I.P.)	Yes	Independent Procedure	Procedure only covered in Bons Cork, Blackrock Clinic, MPH Dublin and SVPH (a) Clinical indications for metabolic surgery to correct diabetes, chronic heart failure, sleep apnoea, hypertension and improve fertility are payable only once in a lifetime and the benefit is subject to pre-certification (b) Benefit is restricted to those patients who satisfy all of the following criteria: (i) Benefit is restricted to those patients whose BMI is currently and has been for at least 2 years greater than 40 and less than or equal to 50 (ii) Bariatric surgery is only payable in hospitals listed in the Irish Life Health directory of Hospitals and has a multi-disciplinary programme for the treatment of obesity (iii) The multi disciplinary team must consist of a consultant recognised by Irish Life Health who has a special interest in the management of obesity, endocrinologist, diabetologist (iv) Patients that are seeking metabolic surgery for severe obesity must have received management in an appropriate programme with integrated components of a dietary regime, appropriate exercise and behavioural modification and support for at least 6 months within 2 years of the proposed surgery and be supported with relevant documentation (v) Patients must be 18 years or older (vi) Evidence must be provided that all appropriate measures have been adequately tried but the member has failed to maintain weight loss (vii) Patients who are candidates for surgical procedures must have been evaluated by a multi-disciplinary team including dietician, a physiotherapist, nurse, psychological, consultant Physician with a special interest in this field and a consultant Surgeon with a special interest in bariatric surgery. Arrangements must be in place for thee appropriate healthcare professionals (as listed above) to provide pre-operative and post-operative counselling and support to patients (viii) Psychological clearance must be obtained through a consultant Psychiatrist or a clinical Psychologist registered with the Psychological Society of Ireland. There should be no specific clinical of psychological contra-indications for this type of surgery and documentation to support this must be provided to Irish Life Health (ix) Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up (x) The operation should be performed by a consultant Surgeon who is registered with Irish Life Health for the performance of these procedures (application form upon request) (xi) Lifelong surveillance is advised and thus a report on progress may be required to be sent to Irish Life Health post-surgery on request
Metabolic Surgery	493202	Metabolic surgery - gastric restrictive procedure, with partial gastrectomy, pylorus preserving duodenileostomy and ileostomy (50 to 100 cm common channel) to limit absorption/ biliopancreatic diversion with duodenal switch	Yes		Procedure only covered in Bons Cork, Blackrock Clinic, MPH Dublin and SVPH (a) Clinical indications for metabolic surgery to correct diabetes, chronic heart failure, sleep apnoea, hypertension and improve fertility are payable only once in a lifetime and the benefit is subject to pre-certification (b) Benefit is restricted to those patients who satisfy all of the following criteria: (i) Benefit is restricted to those patients whose BMI is currently and has been for at least 2 years greater than 40 and less than or equal to 50 (ii) Bariatric surgery is only payable in hospitals listed in the Irish Life Health directory of Hospitals and has a multi-disciplinary programme for the treatment of obesity (iii) The multi disciplinary team must consist of a consultant recognised by Irish Life Health who has a special interest in the management of obesity, endocrinologist, diabetologist (iv) Patients that are seeking metabolic surgery for severe obesity must have received management in an appropriate programme with integrated components of a dietary regime, appropriate exercise and behavioural modification and support for at least 6 months within 2 years of the proposed surgery and be supported with relevant documentation (v) Patients must be 18 years or older (vi) Evidence must be provided that all appropriate measures have been adequately tried but the member has failed to maintain weight loss (vii) Patients who are candidates for surgical procedures must have been evaluated by a multi-disciplinary team including dietician, a physiotherapist, nurse, psychological, consultant Physician with a special interest in this field and a consultant Surgeon with a special interest in bariatric surgery. Arrangements must be in place for thee appropriate healthcare professionals (as listed above) to provide pre-operative and post-operative counselling and support to patients (viii) Psychological clearance must be obtained through a consultant Psychiatrist or a clinical Psychologist registered with the Psychological Society of Ireland. There should be no specific clinical of psychological contra-indications for this type of surgery and documentation to support this must be provided to Irish Life Health (ix) Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up (x) The operation should be performed by a consultant Surgeon who is registered with Irish Life Health for the performance of these procedures (application form upon request) (xi) Lifelong surveillance is advised and thus a report on progress may be required to be sent to Irish Life Health post-surgery on request

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Metabolic Surgery	493203	Metabolic surgery - laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (I.P.)	Yes	Independent Procedure	Procedure only covered in Bons Cork, Blackrock Clinic, MPH Dublin and SVPH (a) Clinical indications for metabolic surgery to correct diabetes, chronic heart failure, sleep apnoea, hypertension and improve fertility are payable only once in a lifetime and the benefit is subject to pre-certification (b) Benefit is restricted to those patients who satisfy all of the following criteria: (i) Benefit is restricted to those patients whose BMI is currently and has been for at least 2 years greater than 40 and less than or equal to 50 (ii) Bariatric surgery is only payable in hospitals listed in the Irish Life Health directory of Hospitals and has a multi-disciplinary programme for the treatment of obesity (iii) The multi disciplinary team must consist of a consultant recognised by Irish Life Health who has a special interest in the management of obesity, endocrinologist, diabetologist (iv) Patients that are seeking metabolic surgery for severe obesity must have received management in an appropriate programme with integrated components of a dietary regime, appropriate exercise and behavioural modification and support for at least 6 months within 2 years of the proposed surgery and be supported with relevant documentation (v) Patients must be 18 years or older (vi) Evidence must be provided that all appropriate measures have been adequately tried but the member has failed to maintain weight loss (vii) Patients who are candidates for surgical procedures must have been evaluated by a multi-disciplinary team including dietician, a physiotherapist, nurse, psychological, consultant Physician with a special interest in this field and a consultant Surgeon with a special interest in bariatric surgery. Arrangements must be in place for thee appropriate healthcare professionals (as listed above) to provide pre-operative and post-operative counselling and support to patients (viii) Psychological clearance must be obtained through a consultant Psychiatrist or a clinical Psychologist registered with the Psychological Society of Ireland. There should be no specific clinical of psychological contra-indications for this type of surgery and documentation to support this must be provided to Irish Life Health (ix) Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up (x) The operation should be performed by a consultant Surgeon who is registered with Irish Life Health for the performance of these procedures (application form upon request) (xi) Lifelong surveillance is advised and thus a report on progress may be required to be sent to Irish Life Health post-surgery on request
Metabolic Surgery	493204	Metabolic surgery - laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g. gastric band and subcutaneous port component) benefits include all subsequent restrictive device adjustment(s)	Yes		Procedure only covered in Bons Cork, Blackrock Clinic, MPH Dublin and SVPH (a) Clinical indications for metabolic surgery to correct diabetes, chronic heart failure, sleep apnoea, hypertension and improve fertility are payable only once in a lifetime and the benefit is subject to pre-certification (b) Benefit is restricted to those patients who satisfy all of the following criteria: (i) Benefit is restricted to those patients whose BMI is currently and has been for at least 2 years greater than 40 and less than or equal to 50 (ii) Bariatric surgery is only payable in hospitals listed in the Irish Life Health directory of Hospitals and has a multi-disciplinary programme for the treatment of obesity (iii) The multi disciplinary team must consist of a consultant recognised by Irish Life Health who has a special interest in the management of obesity, endocrinologist, diabetologist (iv) Patients that are seeking metabolic surgery for severe obesity must have received management in an appropriate programme with integrated components of a dietary regime, appropriate exercise and behavioural modification and support for at least 6 months within 2 years of the proposed surgery and be supported with relevant documentation (v) Patients must be 18 years or older (vi) Evidence must be provided that all appropriate measures have been adequately tried but the member has failed to maintain weight loss (vii) Patients who are candidates for surgical procedures must have been evaluated by a multi-disciplinary team including dietician, a physiotherapist, nurse, psychological, consultant Physician with a special interest in this field and a consultant Surgeon with a special interest in bariatric surgery. Arrangements must be in place for thee appropriate healthcare professionals (as listed above) to provide pre-operative and post-operative counselling and support to patients (viii) Psychological clearance must be obtained through a consultant Psychiatrist or a clinical Psychologist registered with the Psychological Society of Ireland. There should be no specific clinical of psychological contra-indications for this type of surgery and documentation to support this must be provided to Irish Life Health (ix) Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up (x) The operation should be performed by a consultant Surgeon who is registered with Irish Life Health for the performance of these procedures (application form upon request) (xi) Lifelong surveillance is advised and thus a report on progress may be required to be sent to Irish Life Health post-surgery on request

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Metabolic Surgery	493205	Metabolic surgery - laparoscopy, surgical, longitudinal gastrectomy (i.e. gastric sleeve) (I.P.)	Yes	Independent Procedure	Procedure only covered in Bons Cork, Blackrock Clinic, MPH Dublin and SVPH (a) Clinical indications for metabolic surgery to correct diabetes, chronic heart failure, sleep apnoea, hypertension and improve fertility are payable only once in a lifetime and the benefit is subject to pre-certification (b) Benefit is restricted to those patients who satisfy all of the following criteria: (i) Benefit is restricted to those patients whose BMI is currently and has been for at least 2 years greater than 40 and less than or equal to 50 (ii) Bariatric surgery is only payable in hospitals listed in the Irish Life Health directory of Hospitals and has a multi-disciplinary programme for the treatment of obesity (iii) The multi disciplinary team must consist of a consultant recognised by Irish Life Health who has a special interest in the management of obesity, endocrinologist, diabetologist (iv) Patients that are seeking metabolic surgery for severe obesity must have received management in an appropriate programme with integrated components of a dietary regime, appropriate exercise and behavioural modification and support for at least 6 months within 2 years of the proposed surgery and be supported with relevant documentation (v) Patients must be 18 years or older (vi) Evidence must be provided that all appropriate measures have been adequately tried but the member has failed to maintain weight loss (vii) Patients who are candidates for surgical procedures must have been evaluated by a multi-disciplinary team including dietician, a physiotherapist, nurse, psychological, consultant Physician with a special interest in this field and a consultant Surgeon with a special interest in bariatric surgery. Arrangements must be in place for thee appropriate healthcare professionals (as listed above) to provide pre-operative and post-operative counselling and support to patients (viii) Psychological clearance must be obtained through a consultant Psychiatrist or a clinical Psychologist registered with the Psychological Society of Ireland. There should be no specific clinical of psychological contra-indications for this type of surgery and documentation to support this must be provided to Irish Life Health (ix) Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up (x) The operation should be performed by a consultant Surgeon who is registered with Irish Life Health for the performance of these procedures (application form upon request) (xi) Lifelong surveillance is advised and thus a report on progress may be required to be sent to Irish Life Health post-surgery on request
Pancreas	771	ERCP sphincterotomy and extraction of stones	No		
Pancreas	772	ERCP sphincterotomy and insertion of endoprosthesis	No		
Pancreas	773	Biopsy of pancreas, percutaneous needle, includes radiological or ultrasound guidance	No		
Pancreas	774	ERCP (endoscopic retrograde cholangiogram of pancreas)	No	Diagnostic	
Pancreas	775	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple - type procedure); with pancreatojejunostomy	No		
Pancreas	776	Pancreatic biopsy	No	Diagnostic	
Pancreas	778	Pancreaticojejunostomy	No		
Pancreas	779	ERCP ampullectomy with insertion of endoprosthesis	No		
Pancreas	780	Distal pancreatectomy including splenectomy	No		
Pancreas	782	ERCP with endoscopic retrograde destruction, lithotripsy of calculus/ calculi, any method	No		
Pancreas	785	Total pancreatectomy, distal, with gastrectomy, splenectomy, duodenectomy, cholecystectomy and resection of distal bile duct	No		
Pancreas	786	Simultaneous pancreas/ kidney transplant	No		
Pancreas	790	Open surgical drainage of pancreatic abscess or pseudocyst	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Pancreas	795	Pancreatotomy for drainage of pancreatitis, abscess or cyst with exploration of biliary and pancreatic duct	No		
Parathyroid Glands	1110	Parathyroid adenoma, excision of	No		
Parathyroid Glands	1111	Transcatheter ablation of function of parathyroid glands	No		
Parathyroid Glands	1112	Parathyroid hyperplasia, excision of (4 glands, frozen section)	No		
Parathyroid Glands	1113	Total parathyroidectomy with auto transplant or mediastinal exploration/ intra-thoracic	No		
Parathyroid Glands	1114	Parathyroid re-exploration	No		
Salivary Glands	1115	Abscess of salivary gland, incision and drainage	No		
Salivary Glands	1120	Fistula of salivary duct, repair of	No		
Salivary Glands	1125	Parotid or submandibular duct, dilatation of	No		
Salivary Glands	1126	Submandibular duct, relocation (I.P.)	No	Independent Procedure	
Salivary Glands	1133	Excision of parotid tumour or parotid gland, lateral lobe, (superficial parotidectomy) with dissection and preservation of facial nerve (I.P.)	No	Independent Procedure	
Salivary Glands	1134	Excision of parotid tumour or parotid gland, total, en bloc removal with sacrifice of facial nerve	No		
Salivary Glands	1135	Excision of parotid tumour or parotid gland, total with dissection and preservation of facial nerve	No		
Salivary Glands	1136	Excision of parotid tumour or parotid gland, lateral lobe, without nerve dissection	No		
Salivary Glands	1140	Salivary calculus, removal of	No	Day Care	
Salivary Glands	1141	Sialendoscopy with sialolithiasis, any method; complicated intraoral (I.P.)	No	Independent Procedure	1 Night Only
Salivary Glands	1150	Submandibular salivary gland, excision of	No		
Salivary Glands	1151	Excision of sublingual gland	No		
Spleen	800	Open splenectomy (I.P.)	No	Independent Procedure	
Spleen	806	Transcatheter ablation of function of spleen	No		
Spleen	807	Aspiration of splenic cysts	No		
Spleen	381229	Laparoscopic splenectomy (I.P.)	No	Independent procedure	
Thyroid	1154	Excision of thyroid cyst	No		
Thyroid	1155	Total/ revision thyroidectomy	No		

GENERAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Thyroid	1157	Partial/ subtotal thyroidectomy	No		
Tongue	1165	Excision of epithelioma of tongue with radical operation on glands	No		
Tongue	1170	Frenectomy (tongue tie)	No	Day Care	
Tongue	1174	Glossectomy; less than one-half tongue	No		
Tongue	1175	Hemiglossectomy	No		
Tongue	1176	Total glossectomy	No		
Tongue	1180	Growths of tongue, diathermy to	No	Side Room	
Tongue	1185	Excision biopsy, oral cavity (I.P.)	No	Independent Procedure, Side Room	
Tongue	1186	Resection of tonsil, tongue base, palate, mandible and radical neck dissection	No		

GYNAECOLOGICAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Cervix	2140	Cervix, amputation of (I.P.)	No	Independent Procedure	
Cervix	2145	Cervix, biopsy of (I.P.)	No	Independent Procedure, Diagnostic, Side Room	
Cervix	2146	Cervix, cone biopsy of (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Cervix	2150	Cervical polyps, removal of (I.P.)	No	Independent Procedure, Side Room	
Cervix	2151	Knife cone biopsy of cervix (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Cervix	2152	Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s) (I.P.)	No	Independent Procedure	
Cervix	2155	Cervix, dilatation of (I.P.)	No	Independent Procedure, Day Care	

GYNAECOLOGICAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Cervix	2160	Cervix, local excision of lesion (I.P.)	No	Independent Procedure, Side Room	
Cervix	2170	Cervix, suture of (I.P.)	No	Independent Procedure	
Cervix	2171	Cervical cerclage (I.P.)	No	Independent Procedure	
Cervix	2172	Cerclage of cervix, during pregnancy through abdominal incision (I.P.)	No	Independent Procedure	
Cervix	2175	Cervix, cautery of (I.P.)	No	Independent Procedure, Side Room	
Cervix	2180	Cervix, examination when medically necessary to perform under anaesthesia (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Cervix	2181	Colposcopy (I.P.)	No	Independent Procedure, Diagnostic, Side Room	
Cervix	2182	Colposcopy with Lletz procedure for lesion removal and/ or laser therapy (I.P.)	No	Independent Procedure, Side Room	
Cervix	2183	Colposcopy and diagnostic biopsy (I.P.)	No	Independent Procedure, Diagnostic, Side Room	
Cervix	2184	Colposcopy and therapeutic loop electrode biopsy(s) of the cervix (I.P.)	No	Independent Procedure, Side Room	
Foetal Medicine	2217	Fetoscopic surgery, using a fetoscope or shunt, and ultrasound guidance, to correct structural malformations	No		Benefit for procedure 2217 is payable where the procedure is performed by a consultant Obstetrician following referral from the attending Consultant for the following indications: (a) In-utero repair of urinary tract obstruction (b) In-utero repair of congenital cystic adenomatoid malformation (c) In-utero repair of extralobar pulmonary sequestration (d) In-utero repair of sacrococcygeal teratoma (e) Fetoscopic laser therapy for treatment of twin-twin transfusion syndrome
Obstetrics	2185	Caesarean hysterectomy	No		
Obstetrics	2190	Caesarean section (grant in aid for obstetrician's fees, only payable when the consultant obstetrician performs the procedure)	No		
Obstetrics	2200	Ectopic pregnancy, surgical management (laparoscopic or open): salpingectomy and/ or salpingo oophorectomy, unilateral or bilateral	No		
Obstetrics	2207	Epidural anaesthesia for vaginal delivery	No		

GYNAECOLOGICAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Obstetrics	2208	General anaesthetic for complications of full-term delivery requiring operative intervention in theatre	No		Benefit for procedure code 2208 is payable when one of the following complications of full term delivery arise: (a) Retained placenta with or without suturing of perineum (b) Vulval haematoma at the time of delivery (c) Primary or secondary post-partum haemorrhage
Terminations	598511	Termination by Dilatation and curettage	No	Independent Procedure	
Terminations	598512	Termination by one or more amniocentesis injections (including delivery of foetus and secundines)	No	Independent Procedure	
Terminations	598513	Termination by one of more vaginal suppositories (including delivery of foetus and secundines)	No	Independent Procedure	
Uterus and Adnexa	2225	Dilatation and curettage (diagnostic or therapeutic) (I.P.)	No	Independent Procedure, Day Care	
Uterus and Adnexa	2235	Microsurgical repair of extensive tubal and peritubal disease consequent on pelvic inflammatory disease and endometriosis including re-implantation of fallopian tube, unilateral	No		
Uterus and Adnexa	2240	Microsurgical repair of extensive tubal and peritubal disease consequent on pelvic inflammatory disease and endometriosis including re-implantation of fallopian tubes, bilateral	No		
Uterus and Adnexa	2241	Surgical repair of extensive tubal and peritubal disease consequent on pelvic inflammatory disease or endometriosis, unilateral or bilateral	No		
Uterus and Adnexa	2244	Hysteroscopy with sampling of endometrium and/ or polypectomy, with or without dilatation and curettage, with removal of leiomyomata (I.P.)	No	Independent Procedure, Day Care	
Uterus and Adnexa	2246	Hysteroscopy with insertion of intrauterine device for menorrhagia (not for contraceptive purposes) (I.P.)	No	Independent Procedure, Side Room	
Uterus and Adnexa	2248	Hysteroscopy (I.P.)	No	Independent Procedure, Side Room	
Uterus and Adnexa	2249	Hysteroscopy, surgical; with complete endometrial resection or ablation for menorrhagia (I.P.)	No	Independent Procedure, Day Care	
Uterus and Adnexa	2250	Total abdominal hysterectomy	No		
Uterus and Adnexa	2251	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/ or polypectomy with or without dilatation and curettage (I.P.)	No	Independent Procedure, Day Care	
Uterus and Adnexa	2253	Total vaginal hysterectomy combined with sacrospinous ligament fixation of vagina and both anterior and posterior pelvic floor repair	No		
Uterus and Adnexa	2255	Radical abdominal hysterectomy for malignancy, with bilateral total pelvic and/ or para-aortic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without salpingo-oophorectomy, with or without removal of tube(s), with or without removal of ovary(s) including robotic approach	No		

GYNAECOLOGICAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Uterus and Adnexa	2256	Total vaginal hysterectomy combined with anterior and posterior pelvic floor repair	No		
Uterus and Adnexa	2257	Total abdominal hysterectomy with unilateral or bilateral salpingo oophorectomy	No		
Uterus and Adnexa	2258	Resection of ovarian malignancy with total abdominal hysterectomy, complete procedure including robotic approach	No		
Uterus and Adnexa	2259	Debulking of ovarian carcinoma with or without omentectomy, complete procedure including robotic approach	No		
Uterus and Adnexa	2260	Sub total abdominal hysterectomy	No		
Uterus and Adnexa	2264	Total vaginal hysterectomy with urethropexy or urethroplasty (I.P.)	No	Independent Procedure	
Uterus and Adnexa	2265	Total vaginal hysterectomy	No		
Uterus and Adnexa	2267	Total vaginal hysterectomy and anterior or posterior pelvic floor repair (I.P.)	No	Independent Procedure	
Uterus and Adnexa	2268	Vaginal hysterectomy with bilateral salpingo-oophorectomy (I.P.)	No	Independent Procedure	
Uterus and Adnexa	2269	Total vaginal hysterectomy combined with sacrospinous ligament fixation of vagina and anterior or posterior pelvic floor repair (I.P.)	No	Independent Procedure	
Uterus and Adnexa	2280	Myomectomy (multiple) including robotic approach (I.P.)	No	Independent Procedure	
Uterus and Adnexa	2281	Laparoscopy, surgical, myomectomy (multiple) (I.P.)	No	Independent Procedure	1 Night Only
Uterus and Adnexa	2285	Myomectomy (simple, single) including robotic approach (I.P.)	No	Independent Procedure	
Uterus and Adnexa	2286	Laparoscopy, surgical, myomectomy (single) (I.P.)	No	Independent Procedure	1 Night Only
Uterus and Adnexa	2288	Laparoscopy, surgical; with partial or total oophorectomy and/ or salpingectomy (include biopsy, and peritoneal wall sampling or brushings) unilateral or bilateral (I.P.)	No	Independent Procedure	1 Night Only
Uterus and Adnexa	2289	Oophorectomy, unilateral or bilateral (complete or partial) (I.P.)	No	Independent Procedure	
Uterus and Adnexa	2300	Ovarian cystectomy by abdominal approach, unilateral or bilateral (ref code 2487 or 2489 if procedure is performed laparoscopically) (I.P.)	No	Independent Procedure	
Uterus and Adnexa	2319	Salpingectomy complete or partial, unilateral or bilateral (I.P.)	No	Independent Procedure	
Uterus and Adnexa	2354	Salpingostomy or salpingolysis, abdominal incision, unilateral or bilateral (ref code 2487 or 2489 if procedure is performed laparoscopically)(I.P.)	No	Independent Procedure	
Uterus and Adnexa	2364	Microsurgical tuboplasty (salpingostomy or salpingolysis), unilateral or bilateral (I.P.)	No	Independent Procedure	

GYNAECOLOGICAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Uterus and Adnexa	2365	Salpingo oophorectomy, complete or partial, unilateral or bilateral (I.P.)	No	Independent Procedure	
Uterus and Adnexa	2370	Uterus, plastic reconstruction of	No	Day Care	
Uterus and Adnexa	2375	Ventrosuspension/ Gilliam's operation (I.P.)	No	Independent Procedure, Day Care	
Uterus and Adnexa	2377	Endoscopic periurethral injection of bulking agents that are approved by FDA for urinary incontinence. Benefit is payable for a maximum of 3 treatments (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for a maximum of 3 treatments per lifetime
Uterus and Adnexa	574155	Laparoscopic sterilisation by ligation of both fallopian tubes, when this sterilisation procedure is recommended by a consultant Obstetrician-Gynaecologist for medical safety reasons due to significant risks to maternal health (I.P.)	Yes	Independent Procedure, Day Care	
Uterus and Adnexa	574157	Laparoscopic hysteroscopy (I.P.)	No	Independent Procedure, Side Room	
Uterus and Adnexa	576012	Prophylactic total abdominal hysterectomy with bilateral salpingo-oophorectomy	Yes		
Uterus and Adnexa	586814	Prophylactic open oophorectomy, bilateral	Yes		
Uterus and Adnexa	592215	Prophylactic laparoscopic oophorectomy, bilateral	Yes		
Uterus and Adnexa	597616	Laparoscopic hysterectomy with bilateral pelvic lymphadenectomy (I.P.)	No	Independent procedure	
Uterus and Adnexa	603017	Prophylactic laparoscopically assisted vaginal hysterectomy with bilateral salpingo-oophorectomy	Yes		
Uterus and Adnexa	858405	Laparoscopic sub-total hysterectomy with or without removal of tube(s) and/or ovary(ies)	No		
Uterus and Adnexa	2289R	Oophorectomy, risk reducing prophylactic, unilateral or bilateral (complete or partial) (I.P.)	Yes	Independent Procedure	Cover must be requested in advance and only by way of the standard template available from Irish Life Health
Uterus and Adnexa	2365R	Salpingo oophorectomy, risk reducing prophylactic, complete or partial, unilateral or bilateral (I.P.)	Yes	Independent Procedure	Cover must be requested in advance and only by way of the standard template available from Irish Life Health
Vulvovaginal	2380	Atresia vaginae, relief of (including dilatation of vulva and vagina) (I.P.)	No	Independent Procedure, Day Care	
Vulvovaginal	2385	Bartholin's gland cyst, excision of	No	Day Care	
Vulvovaginal	2390	Bartholin's or Skene's gland, abscess of, incision and drainage (I.P.)	No	Independent Procedure	
Vulvovaginal	2395	Caruncle, vulvovaginal, removal of (I.P.)	No	Independent Procedure, Day Care	
Vulvovaginal	2400	Colporrhaphy with amputation of cervix, anterior and posterior (Manchester or Fothergill operation) (I.P.)	No	Independent Procedure	

GYNAECOLOGICAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Vulvovaginal	2410	Colpotomy	No	Day Care	
Vulvovaginal	2411	Laparoscopy, surgical, sacrocolpopexy including robotic approach (I.P.)	No	Independent Procedure	
Vulvovaginal	2415	Cystocele, repair of (I.P.)	No	Independent Procedure	
Vulvovaginal	2420	Cystocele and rectocele, repair of (including colpoperineorraphy)	No		
Vulvovaginal	2425	Cysts or simple tumours of the vulva or vagina, excision of	No	Day Care	
Vulvovaginal	2426	Repair of enterocele, vaginal or abdominal approach (I.P.)	No	Independent Procedure	
Vulvovaginal	2430	Hymenotomy (I.P.)	No	Independent Procedure, Day Care	
Vulvovaginal	2435	Hymenectomy (I.P.)	No	Independent Procedure, Day Care	
Vulvovaginal	2440	Perineal tear, (excludes child birth and 1st of 2nd degree tears) complete, repair of (I.P.)	No	Independent Procedure	
Vulvovaginal	2441	Partial vaginectomy (I.P.)	No	Independent Procedure	
Vulvovaginal	2444	Retropubic urethropexy or vesicourethropexy (including colposuspension) (e.g. Burch, MMK)	No		
Vulvovaginal	2445	Rectocele, repair of (I.P.)	No	Independent Procedure	
Vulvovaginal	2450	Abdomino-vaginal suspension of bladder neck for stress incontinence (e.g. Stamey, Raz)	Yes		
Vulvovaginal	2461	Closure of rectovaginal fistula; vaginal or transanal approach (I.P.)	No	Independent Procedure	
Vulvovaginal	2462	Closure of rectovaginal fistula; abdominal approach with or without colostomy (I.P.)	No	Independent Procedure	
Vulvovaginal	2465	Vaginal fistulae (vesico vaginal), repair of	No		
Vulvovaginal	2470	Vaginal wall, suture of non-obstetrical tear due to trauma	No		
Vulvovaginal	2471	Sacrospinous ligament fixation for prolapse of vagina (I.P.)	No	Independent Procedure	
Vulvovaginal	2472	Colpopexy, intra-peritoneal approach (uterosacral, levator myorrhaphy) (I.P.)	No	Independent Procedure	Where procedure code 2472 or 2474 is carried out at the same time as a hysterectomy, code 2267 will apply
Vulvovaginal	2473	Colpocleisis (Le Fort type)	No		
Vulvovaginal	2474	Colpopexy, vaginal; extra - peritoneal approach (sacrospinous, ilioccygeus) (I.P.)	No	Independent Procedure	Where procedure code 2472 or 2474 is carried out at the same time as a hysterectomy, code 2267 will apply

GYNAECOLOGICAL PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Vulvovaginal	2480	Vulvectomy, simple, without glands	No		
Vulvovaginal	2481	Laparoscopy, surgical, with total hysterectomy, with or without removal of tube(s) and/ or ovary(s) including robotic approach (I.P.)	No	Independent Procedure	
Vulvovaginal	2482	Laparoscopic radical hysterectomy for malignancy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without salpingo-oophorectomy including robotic approach (I.P.)	No	Independent Procedure	
Vulvovaginal	2483	Laparoscopy, surgical, vaginal hysterectomy, with or without removal of tube(s) and/ or ovary(s) including robotic approach (I.P.)	No	Independent Procedure	
Vulvovaginal	2484	Diagnostic laparoscopy with or without biopsy, with or without tubal irrigation/ insufflation (I.P.)	No	Independent Procedure, Day Care	
Vulvovaginal	2485	Vulvectomy, radical, with glands	No		
Vulvovaginal	2487	Laparoscopy with or without biopsy and one or more of the following procedures: excision of lesions of ovary(ies); (ovarian cystectomy), solid tumours (e.g. large endometriomas or dermoid) pelvic viscera or peritoneal surface; diathermy of endometriosis; division of adhesions; puncture of cysts. This procedure may or may not include tubal irrigation/ insufflation (I.P.)	No	Independent Procedure, Day Care	
Vulvovaginal	2488	Laparoscopy with or without biopsy. This procedure also includes dilatation and curettage (diagnostic or therapeutic), with or without tubal irrigation/ insufflation (I.P.)	No	Independent Procedure, Day Care	
Vulvovaginal	2489	Laparoscopy with or without biopsy and one or more of the following procedures: excision of lesions of ovary(ies) (ovarian cystectomy), solid tumours (e.g. large endometrioma or dermoid); pelvic viscera or peritoneal surface; diathermy of endometriosis; division of adhesions; puncture of cysts; lymph nodes sampling (biopsy) single or multiple. This procedure also includes dilatation and curettage (diagnostic or therapeutic), with or without tubal irrigation/ insufflation including robotic approach (I.P.)	No	Independent Procedure, Day Care	
Vulvovaginal	257295	Removal and repair of mesh devices in uro-gynaecological procedures	Yes		Only payable to consultant Gynaecologists on specialist register in designated HSE facilities -NMHS, SVUH, CUH
Vulvovaginal	574156	Laparoscopic colpopexy (I.P.)	No	Independent Procedure	
Vulvovaginal	581413	Prophylactic vaginal hysterectomy with bilateral salpingo-oophorectomy	Yes		

MEDICAL ADMISSIONS

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Blood and Lymphatics	1642	Isolated limb perfusion including exposure of major limb artery and vein, arteriotomy and venotomy	No		

MEDICAL ADMISSIONS

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Central Venous Access	1573	Removal of tunnelled central venous catheter with subcutaneous access port under local anaesthetic, with or without sedation	No	Side Room, Monitored Anaesthesia Care	Where it is medically necessary for a patient to be admitted to hospital as an in-patient, the in-patient attendance daily rates of benefit only are payable These procedures are not for monitoring central venous pressure In exceptional circumstances where there is a requirement for medical reasons for a consultant other than the primary consultant to carry out procedure code 1628, 1634 1626, or 1627 benefit will be paid to the second consultant Repeat procedures performed by the second consultant are payable where line sepsis associated with neutropenia and general debilitation occur Please report full details on a claim form or on a separate report The benefit does not apply to the admitting consultant nor is it payable in addition to the benefit for a consultation The benefits for procedure codes 1628, 1634, and 1627 does not apply to patients being treated in intensive care units as the intensive care benefit is inclusive of these procedures
Central Venous Access	1574	Insertion of tunnelled central venous catheter with subcutaneous access port (I.P.)	No	Independent Procedure, Side Room	Where it is medically necessary for a patient to be admitted to hospital as an in-patient, the in-patient attendance daily rates of benefit only are payable These procedures are not for monitoring central venous pressure In exceptional circumstances where there is a requirement for medical reasons for a consultant other than the primary consultant to carry out procedure code 1628, 1634 1626, or 1627 benefit will be paid to the second consultant Repeat procedures performed by the second consultant are payable where line sepsis associated with neutropenia and general debilitation occur Please report full details on a claim form or on a separate report The benefit does not apply to the admitting consultant nor is it payable in addition to the benefit for a consultation The benefits for procedure codes 1628, 1634, and 1627 does not apply to patients being treated in intensive care units as the intensive care benefit is inclusive of these procedures
Central Venous Access	1626	Insertion of tunnelled central venous access with externalized catheter end	No	Side Room	Where it is medically necessary for a patient to be admitted to hospital as an in-patient, the in-patient attendance daily rates of benefit only are payable These procedures are not for monitoring central venous pressure In exceptional circumstances where there is a requirement for medical reasons for a consultant other than the primary consultant to carry out procedure code 1626, 1627, 1628 or 1634 benefit will be paid to the second consultant Repeat procedures performed by the second consultant are payable where line sepsis associated with neutropenia and general debilitation occur Please report full details on a claim form or on a separate report The benefit does not apply to the admitting consultant nor is it payable in addition to the benefit for a consultation The benefits for procedure codes 1627, 1628 or 1634 do not apply to patients being treated in intensive care units as the intensive care benefit is inclusive of these procedures To qualify as a central venous access catheter or device, the tip of the catheter/ device must terminate in the subclavian, brachiocephalic (innominate) or iliac veins, the superior of inferior cava or the right atrium The venous access device may be either centrally inserted (jugular, subclavian, femoral vein or inferior vena cava catheter entry site) or peripherally inserted (e.g. basilic or cephalic vein) The device may be accessed for use either via exposed catheter (external to the skin), via a subcutaneous port or via a subcutaneous pump
Central Venous Access	1627	Removal of catheter from central venous system, when it is medically necessary to perform this procedure under general anaesthetic, on completion of therapy or because of complications with the catheter (I.P.)	No	Independent Procedure, Day Care	Where it is medically necessary for a patient to be admitted to hospital as an in-patient, the in-patient attendance daily rates of benefit only are payable These procedures are not for monitoring central venous pressure In exceptional circumstances where there is a requirement for medical reasons for a consultant other than the primary consultant to carry out procedure code 1626, 1627, 1628 or 1634 benefit will be paid to the second consultant Repeat procedures performed by the second consultant are payable where line sepsis associated with neutropenia and general debilitation occur Please report full details on a claim form or on a separate report The benefit does not apply to the admitting consultant nor is it payable in addition to the benefit for a consultation The benefits for procedure codes 1627, 1628 or 1634 do not apply to patients being treated in intensive care units as the intensive care benefit is inclusive of these procedures To qualify as a central venous access catheter or device, the tip of the catheter/ device must terminate in the subclavian, brachiocephalic (innominate) or iliac veins, the superior of inferior cava or the right atrium The venous access device may be either centrally inserted (jugular, subclavian, femoral vein or inferior vena cava catheter entry site) or peripherally inserted (e.g. basilic or cephalic vein) The device may be accessed for use either via exposed catheter (external to the skin), via a subcutaneous port or via a subcutaneous pump

MEDICAL ADMISSIONS

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Central Venous Access	1634	Placement of non tunnelled central venous catheter (peripherally or centrally inserted)	No	Side Room	Where it is medically necessary for a patient to be admitted to hospital as an in-patient, the in-patient attendance daily rates of benefit only are payable These procedures are not for monitoring central venous pressure In exceptional circumstances where there is a requirement for medical reasons for a consultant other than the primary consultant to carry out procedure code 1626, 1627, 1628 or 1634 benefit will be paid to the second consultant Repeat procedures performed by the second consultant are payable where line sepsis associated with neutropenia and general debilitation occur Please report full details on a claim form or on a separate report The benefit does not apply to the admitting consultant nor is it payable in addition to the benefit for a consultation The benefits for procedure codes 1627, 1628 or 1634 do not apply to patients being treated in intensive care units as the intensive care benefit is inclusive of these procedures To qualify as a central venous access catheter or device, the tip of the catheter/ device must terminate in the subclavian, brachiocephalic (innominate) or iliac veins, the superior of inferior cava or the right atrium The venous access device may be either centrally inserted (jugular, subclavian, femoral vein or inferior vena cava catheter entry site) or peripherally inserted (e.g. basilic or cephalic vein) The device may be accessed for use either via exposed catheter (external to the skin), via a subcutaneous port or via a subcutaneous pump
Excisions	1554	Surgical excision of benign lesion or lesions of face, neck, ear or genitalia (includes sebaceous cysts) (I.P.)	No	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hopsital Admission" applies. This benefit covers both the professional and the facility fee Where a second procedure is performed on day of initial procedure then 75% of second procedure will be paid to consultant only, even if undertaken in a hospital setting (i.e. no technical fee will apply) Any subsequent claims for lesion removal at or near the originating site within 120 days will not be paid
Excisions	4210	Plantar warts, complete surgical excision, one or more (not local application, cryotherapy or curettage etc.)	No	Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hopsital Admission" applies. This benefit covers both the professional and the facility fee
Excisions	170555	Multiple stage surgical excision of benign lesion for congenital naevi (includes sebaceous cysts) (I.P.)	Yes	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hopsital Admission" applies. This benefit covers both the professional and the facility fee
Nail	3120	Nail, removal of	No	Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hopsital Admission" applies. This benefit covers both the professional and the facility fee
Nail	4160	Excision of nail and nail matrix, partial or complete (e.g. ingrown or deformed nail), for permanent removal	No	Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hopsital Admission" applies. This benefit covers both the professional and the facility fee
Opthalmology	2505	Foreign body, removal of, from conjunctiva	No	Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hopsital Admission" applies. This benefit covers both the professional and the facility fee
Opthalmology	2520	Conjunctival wounds, repair	No	Day Care	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hopsital Admission" applies. This benefit covers both the professional and the facility fee
Wounds	1602	Wounds from 2.6 cm to 7.5 cm in total length, suture or staple of lacerated or torn tissue, single or multi layered closure with or without irrigation or debridement (I.P.)	No	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hopsital Admission" applies. This benefit covers both the professional and the facility fee Benefit includes wound closure by tissue adhesives (e.g. two-cyanoacrylate) either singly or in combination with sutures or staples or in combination with adhesive strips Wound closures utilising adhesive strips as the sole repair material may only be claimed under ILH out-patient benefit

MINOR PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
ENT	1800	Epistaxis - anterior packing and/ or cautery (I.P.)	No	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee

MINOR PROCEDURES

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Excisions	405	Destruction of lesion(s) by any method, genital/ anal warts (e.g. condyloma, papilloma, molluscum contagiosum, herpetic vesicle) where performed under general anaesthetic in an Irish Life Health approved hospital (I.P.)	No	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee
Excisions	1505	Abscess, cyst or tumour, aspiration of (I.P.)	No	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee
Excisions	1540	Skin abscess, (superficial) incision and drainage of (I.P.)	No	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee
Excisions	1546	Enucleation or excision of lipoma	No	Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee
Excisions	1552	Surgical excision of benign lesion or lesions from body other than face, ear, neck and/ or genitalia (includes sebaceous cysts) (I.P.)	No	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee Where a second procedure is performed on day of initial procedure then 75% of second procedure will be paid to consultant only, even if undertaken in a hospital setting (i.e. no technical fee will apply) Any subsequent claims for lesion removal at or near the originating site within 120 days will not be paid
Excisions	1554	Surgical excision of benign lesion or lesions of face, neck, ear or genitalia (includes sebaceous cysts) (I.P.)	No	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee Where a second procedure is performed on day of initial procedure then 75% of second procedure will be paid to consultant only, even if undertaken in a hospital setting (i.e. no technical fee will apply) Any subsequent claims for lesion removal at or near the originating site within 120 days will not be paid
Excisions	170555	Multiple stage surgical excision of benign lesion for congenital naevi (includes sebaceous cysts) (I.P.)	No	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee
Nail	3120	Nail, removal of	No	Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee
Ophthalmology	2505	Foreign body, removal of, from conjunctiva	No	Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee
Ophthalmology	2520	Conjunctival wounds, repair	No	Day Care	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee
Wounds	1602	Wounds from 2.6 cm to 7.5 cm in total length, suture or staple of lacerated or torn tissue, single or multi layered closure with or without irrigation or debridement (I.P.)	No	Independent Procedure, Side Room	Where this procedure is done in a setting which does not require hospital admission, the "Participating Benefit - No Hospital Admission" applies. This benefit covers both the professional and the facility fee Benefit includes wound closure by tissue adhesives (e.g. two-cyanoacrylate) either singly or in combination with sutures or staples or in combination with adhesive strips Wound closures utilising adhesive strips as the sole repair material may only be claimed under ILH out-patient benefit

NEURO SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Arteries/ Veins	5290	Clipping aneurysm, anterior circulation (open procedure)	No		
Arteries/ Veins	5292	Detachable balloon occlusion of carotico cavernous aneurysms and fistulae	No		

NEURO SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Arteries/ Veins	5713	Contra-lateral carotid and vertebral angiography performed at the same session as procedure codes 5711 or 5712 above (benefit shown is payable in full with the code for the main procedure)	No		Benefit is payable in full when performed with code 5711 or 5712 Benefit shown is payable in full with the code for the main procedure
Arteries/ Veins	5779	Arteriovenous malformation, simple (< Spetzler 3)	No		
Arteries/ Veins	5781	Arteriovenous malformation, complex (> Spetzler 3)	No		
Arteries/ Veins	5782	Dural arteriovenous malformation	No		
Arteries/ Veins	5783	Clipping aneurysm, posterior circulation (open procedure)	No		
Arteries/ Veins	5784	Anastomosis, arterial, extracranial-intracranial (e.g. middle cerebral/ cortical) arteries	No		
Burr Hole	5490	Burr hole for excavation and/ or drainage of subdural haematoma	No		
Burr Hole	5645	Burr hole(s) for brain biopsy/ abscess tapping	No	Diagnostic	
Burr Hole	5650	Burr hole for ventricular puncture or intensive care monitoring (I.P.)	No	Independent Procedure	
Burr Hole	5706	Twist drill, burr hole, craniotomy or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g. thalamus, globus pallidus, subthalamic, nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording	No		
Burr Hole	5707	Twist drill, burr hole, craniotomy or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g. thalamus, globus pallidus, subthalamic, nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording	No		
Burr Hole	5744	Burr hole(s) for brain biopsy/ abscess tapping/ implanting ventricular catheter, reservoir, EEG electrode(s) or pressure recording device	No		
Consultation	5691	Consultant plastic surgeon, cranio facialplasty, including the correction of craniosynostoses and facial synostoses	No		
Consultation	647010	Co-surgery benefit for two surgeons who perform neuroendoscopy, intracranial; with excision of pituitary tumour, transnasal or transsphenoidal approach (I.P.) - Neurosurgeons benefit	No	Independent procedure	Claimable by second surgeon assisting in procedure
Consultation	647011	Co-surgery benefit for two surgeons who perform spinal surgery (I.P.) - ENT Surgeons benefit	Yes	Independent procedure	Claimable by second surgeon assisting in procedure
Craniectomy	5295	Craniectomy or craniotomy for cerebellar haematoma	No		
Craniectomy	5320	Craniectomy for excision of brain tumour, supratentorial	No		
Craniectomy	5365	Craniectomy for meningioma, supratentorial	No		
Craniectomy	5410	Craniectomy or craniotomy for intracerebral haematoma	No		
Craniectomy	5420	Craniectomy or craniotomy for abscess	No		

NEURO SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Craniectomy	5470	Craniotomy for removal of pituitary tumour or to resect a portion of gland	No		
Craniectomy	5751	Craniectomy for foramen magnum decompression (A-C; syringo)	No		
Craniectomy	5752	Craniectomy for nerve section/ decompression	No		
Craniectomy	5753	Craniectomy for bone tumour, supratentorial	No		
Craniectomy	5754	Craniectomy for excision of brain tumour, infratentorial	No		
Craniectomy	5757	Craniectomy for meningioma, infratentorial	No		
Craniectomy	5758	Craniectomy for cerebellopontine angle tumour (includes acoustic neuroma)	No		
Craniectomy	5759	Craniectomy for midline skull base tumour	No		
Craniectomy	5768	Craniectomy for excision/ fenestration cyst	No		
Craniectomy	5774	Craniectomy for repair of skull base, encephalocoele	No		
Craniectomy/ Craniotomy	5747	Craniectomy or craniotomy, exploratory, supratentorial (I.P.)	No	Independent Procedure	
Craniectomy/ Craniotomy	5748	Craniectomy or craniotomy, exploratory, infratentorial (I.P.)	No	Independent Procedure	
Craniectomy/ Craniotomy	5749	Craniectomy or craniotomy for extra/ subdural haematoma	No		
Craniotomy	5376	Craniotomy for excision epileptic focus	No		
Craniotomy	5377	Craniotomy for lobectomy (epilepsy) with electrocorticography during surgery (includes removal of electrode array)	No		
Craniotomy	5378	Craniotomy with elevation of bone flap (for intractable epileptic seizures); for lobectomy, temporal, temporal lobe, without electrocorticography during surgery	No		
Craniotomy	5379	Craniotomy with elevation of bone flap (to treat intractable mesial temporal lobe epilepsy); for selective amygdalohippocampectomy	No		
Craniotomy	5764	Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring	No		
Craniotomy	5766	Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue	No		
Craniotomy	5767	Craniotomy for transection of corpus callosum	No		
Craniotomy	5769	Craniotomy for excision of craniopharyngioma (complete removal)	No		
Craniotomy	5776	Craniofacial approach to anterior cranial fossa; intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa	No		

NEURO SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Other Neurosurgical Procedures	5325	Penetrating brain injury with removal foreign body	No		
Other Neurosurgical Procedures	5370	CSF leak repair via craniectomy or nasal endoscopy (I.P.)	No	Independent Procedure	
Other Neurosurgical Procedures	5400	Hemispherectomy	No		
Other Neurosurgical Procedures	5590	Intracranial sensory root division (trigeminal)	No		
Other Neurosurgical Procedures	5665	Elevation depressed skull fracture	No		
Other Neurosurgical Procedures	5690	Excision of osteoma calvarium	No	Day Care	
Other Neurosurgical Procedures	5693	Skull bone grafting to facial skeleton	No		
Other Neurosurgical Procedures	5695	Repair of platybasia	No		
Other Neurosurgical Procedures	5708	Revision or removal of intracranial neurostimulator electrodes	No		
Other Neurosurgical Procedures	5711	Percutaneous transcatheter occlusion or embolisation of tumour, acute haemorrhage, vascular malformation or aneurysm includes angioplasty, stenting or clot extraction from any vessel(s) external or internal carotid or vertebral arteries including distal branches; includes angiographic evaluation before, during and after the procedure, at the same session	No		Code 5711 is not claimable with Code 5712
Other Neurosurgical Procedures	5712	Percutaneous transcatheter occlusion or embolisation of tumour, acute haemorrhage, vascular malformation or aneurysm includes angioplasty, stenting or clot extraction from any vessel(s) external or internal carotid or vertebral arteries including distal branches; including any combination of more than one of the following: microcatheter, balloon catheter; stent catheter or clot retrieval device required for complex embolisation; includes angiographic evaluation before, during and after the procedure, at the same session	No		Code 5712 is not claimable with Code 5711
Other Neurosurgical Procedures	5725	Anomalies of cord vascular, operation for	No		
Other Neurosurgical Procedures	5756	Intrathecal cytotoxic chemotherapy infusion	No	Side Room	
Other Neurosurgical Procedures	5763	Exploration of the brachial plexus with removal of tumours	No		
Other Neurosurgical Procedures	5771	Nerve root tumours, transthoracic or abdominal removal	No		

NEURO SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Other Neurosurgical Procedures	5772	Single surgeon transnasal or transseptal approach to remove a pituitary tumour or resect a portion of gland (I.P.)	No	Independent Procedure	
Other Neurosurgical Procedures	5773	Repair of encephalocoele, skull vault, including cranioplasty	No		
Other Neurosurgical Procedures	5777	Infratemporal post-auricular approach to middle cranial fossa (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus with or without decompression and/ or mobilization of contents of auditory canal or petrous carotid artery	No		
Other Neurosurgical Procedures	5778	Trans cochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/ or petrous carotid artery	No		
Other Neurosurgical Procedures	5786	Stereotactic lesioning (functional)	No		
Other Neurosurgical Procedures	5787	Stereotactic biopsy (CT or MRI targeted)	No		
Other Neurosurgical Procedures	5788	Cranioplasty for skull defect (I.P.)	No	Independent Procedure	
Other Neurosurgical Procedures	5789	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion (I.P.)	No	Independent Procedure	
Other Neurosurgical Procedures	5791	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/ or temporal lobe(s) (I.P.)	No	Independent Procedure	
Other Neurosurgical Procedures	5792	Transtemporal approach to posterior cranial fossa, jugular foramen or midline skull base, including mastoidectomy, decompression of sigmoid sinus and/ or facial nerve (I.P.)	No	Independent Procedure	
Other Neurosurgical Procedures	5797	Endoscopic third ventriculostomy or cyst fenestration	No		
Shunts	5520	Shunt insertion	No		
Shunts	5525	Shunt revision	No		
Shunts	5796	Shunt removal	No		
Sympathectomy	5761	Cervical sympathectomy, unilateral	No		
Sympathectomy	5762	Cervical sympathectomy, bilateral	No		
Sympathectomy	5765	Lumbar sympathectomy, unilateral	No		
Sympathectomy	5770	Lumbar sympathectomy, bilateral	No		

OPHTHALMOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Anterior Segment	2523	Removal of foreign body from anterior chamber, non-magnetic	No		
Anterior Segment	2524	Removal of implanted material from anterior chamber	No		
Anterior Segment	2525	Paracentesis of anterior chamber of eye with or without diagnostic aspiration of aqueous (I.P.)	No	Independent Procedure, Day Care	
Anterior Segment	2580	Paracentesis of anterior chamber of eye for hyphaema with or without irrigation and/ or air injection	No		
Anterior Segment	2586	Reform anterior chamber secondary to trabeculectomy or post cataract surgery	No	Day Care	
Anterior Segment	266835	Implantation of iStent	No		For patients with mild to moderate open angle glaucoma undergoing cataract surgery or having previously had cataract surgery who require additional intraocular pressure control and for patients who experience side effects of topical drops, poor tolerance of topical drops due to severe dry eye, allergy or other systemic disease interactions, poor adherence to drop treatment regime or difficulty inserted drops due to coexisting illness or disability
Conjunctiva	2490	Conjunctival flap	No		
Conjunctiva	2493	Conjunctivectomy	No		
Conjunctiva	2495	Conjunctival graft	No		
Conjunctiva	2496	Cryotherapy, unilateral	No	Day Care	
Conjunctiva	2497	Cryotherapy, bilateral	No	Day Care	
Conjunctiva	2498	Conjunctival tumour with or without graft	No	Day Care	
Conjunctiva	2500	Conjunctival cyst/ granuloma, one or more excision of	No	Side Room	
Conjunctiva	2521	Symblepharon division	No		
Conjunctiva	2522	Removal of foreign body from anterior chamber, magnetic	No	Day Care	
Conjunctiva	2526	Symblephora, division of (includes conjunctival graft)	No		
Conjunctiva	2527	Conjunctival biopsy	No	Side Room	
Cornea and Sclera	2510	Pterygium removal	No	Day Care	
Cornea and Sclera	2511	Pterygium removal and conjunctival graft	No	Day Care	
Cornea and Sclera	2530	Corneal grafting of un-cut graft, penetrating/ lamellar	No		
Cornea and Sclera	2531	Removal of sutures (late stage) post corneal grafting; corneal/ sclera	No	Side Room, Local Anaesthetic	
Cornea and Sclera	2535	Corneal surface removed and EDTA application	No	Side Room, Monitored Anaesthesia Care	
Cornea and Sclera	2540	Corneal tattooing	No		
Cornea and Sclera	2546	Corneal scraping	No	Day Care	
Cornea and Sclera	2547	Corneal biopsy	No		

OPHTHALMOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Cornea and Sclera	2548	Ulcer/ recurrent erosion, surgical treatment/ cautery with or without pricking, with or without debridement, with or without cryotherapy, one or more treatments, per episode of illness	No	Side Room	
Cornea and Sclera	2549	Corneal grafting of pre-cut graft, penetrating/ lamellar (not INTACS)	No		
Cornea and Sclera	2555	Corneal or scleral tumour, excision	No		
Cornea and Sclera	2556	Perforating injury cornea and/ or sclera not involving uveal tissue	No		
Cornea and Sclera	2565	Perforating injury cornea and/ or sclera with reposition or resection of uveal tissue	No		
Cornea and Sclera	2566	Repair of scleral staphyloma with or without graft	No		
Cornea and Sclera	2575	Foreign body, removal of, from cornea	No	Side Room	
Cornea and Sclera	2577	Keratotomy, corneal relaxing incision or wedge resection for correction of surgically induced astigmatism that resulted from previous surgery (not for the correction of refractive errors to correct short sightedness, long sightedness or astigmatism) (I.P.)	No	Independent Procedure, Day Care	
Cornea and Sclera	2579	Excimer laser therapy for the correction of corneal diseases e.g. corneal dystrophy, epithelial membrane dystrophy, irregular corneal surfaces due to Salzmann's nodular degeneration or keratoconus nodules, or post traumatic corneal scars and opacities or recurrent corneal erosions. Not for the correction of refractive errors (LASIK), the treatment of infectious keratitis or for the correction of post surgical corneal scars that arise as a result of surgery for which Irish Life Health benefit is not payable	No	Side Room	Details of previous cataract surgery must be provided on the claim form
Eyelids	2592	Repair of ectropion; suture or thermo cauterization	No	Side Room	
Eyelids	2595	Repair of ectropion; excision of tarsal wedge/ extensive (e.g. tarsal strip operations)	No	Day Care	
Eyelids	2596	Blepharophimosis, for pathology (not cosmetic)	No	Day Care	
Eyelids	2600	Repair of entropion; excision tarsal wedge/ extensive (e.g. tarsal strip or capsulopalpebral fascia repairs operation)	No	Day Care	
Eyelids	2601	Repair of entropion; suture or thermo cauterization	No	Side Room	
Eyelids	2610	Injury to eyelid, repair (superficial)	No	Side Room, Local Anaesthetic	
Eyelids	2611	Opening of tarsorrhaphy (I.P.)	No	Independent Procedure, Side Room, Local Anaesthetic	
Eyelids	2615	Injury to eyelid, repair (deep)	No		
Eyelids	2621	Excision of chalazion, papilloma, dermoid or other cyst or lesion, single, involving skin, lid margin, tarsus, and/ or palpebral conjunctiva (I.P.)	No	Independent Procedure, Side Room	

OPHTHALMOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Eyelids	2622	Excision of chalazions, papilloma's, dermoids or other cysts or lesions, one or both eyelids, involving skin, lid margin, tarsus and/ or palpebral conjunctiva (I.P.)	No	Independent Procedure, Side Room, Local Anaesthetic	
Eyelids	2630	Tarsorrhaphy	No	Day Care	
Eyelids	669901	Dermatochalasis causing visual field obstruction (not cosmetic)	No	Day Care	
Globe	2635	Evisceration of eye	No		
Globe	2640	Excision of eye plus implant	No		
Globe	2645	Removal of intraocular foreign body	No		
Globe	2660	Removal of eye	No		
Intravitreal - Iluvien	669580	Left eye, implantation of 190mcg Iluvien flucinone acetone device (I.P.)	Yes	Independent Procedure, Side Room	Treatment of vision impairments caused by Chronic diabetic macular oedema (DMO) , that is unresponsive to available therapies
Intravitreal - Iluvien	669581	Right eye, implantation of 190mcg Iluvien flucinone acetone device (I.P.)	Yes	Independent Procedure, Side Room	Treatment of vision impairments caused by Chronic diabetic macular oedema (DMO) , that is unresponsive to available therapies
Intravitreal Injections	2528	Intravitreal injection of a pharmacological agent with or without paracentesis. Only for use where the intravitreal agents are not listed separately in this schedule (I.P.)	No	Independent Procedure, Side Room	Not for use where the intravitreal agents are listed separately in this Schedule The intravitreal agent used must be stated on the claim form If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Avastin	2551	Left eye, intravitreal injection of Avastin for treatment of visual impairment due to diabetic macular oedema (DME) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Avastin	2552	Right eye, intravitreal injection of Avastin for treatment of visual impairment due to diabetic macular oedema (DME) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Avastin	2553	Left eye, intravitreal injection of Avastin for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Avastin	2554	Right eye, intravitreal injection of Avastin for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies

OPHTHALMOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Intravitreal Injections - Avastin	2567	Left eye, intravitreal injection of Avastin for the treatment of visual impairment due to macular oedema secondary to retinal vein occlusion (RVO) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Avastin	2568	Right eye, intravitreal injection of Avastin for the treatment of visual impairment due to macular oedema secondary to retinal vein occlusion (RVO) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Avastin	669551	Bilateral, intravitreal injection of Avastin for treatment of visual impairment due to diabetic macular oedema (DME) (I.P.)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Avastin	669555	Bilateral, intravitreal injection of Avastin for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Avastin	669569	Bilateral, intravitreal injection of Avastin for the treatment of visual impairment due to macular oedema secondary to retinal vein occlusion (RVO) (I.P.)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Avastin	669573	Bilateral, intravitreal injection of Eylea (Aflibercept) for the treatment of visual impairment due to macular oedema secondary to central retinal vein occlusion (CRVO) or branch retinal vein occlusion (I.P.)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Eylea	2559	Intravitreal injection of Eylea (Aflibercept) (bilateral) for the treatment of visual impairment due to diabetic macular oedema (DME) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Eylea	2561	Left eye, intravitreal injection of Eylea (Aflibercept) for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Eylea	2562	Right eye, intravitreal injection of Eylea (Aflibercept) for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies

OPHTHALMOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Intravitreal Injections - Eylea	2563	Intravitreal injection of Eylea (aflibercept) (bilateral) for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Eylea	2564	Left eye, intravitreal injection of Eylea (Aflibercept) for the treatment of visual impairment due to diabetic macular oedema (DME) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Eylea	2569	Right eye, intravitreal injection of Eylea (Aflibercept) for the treatment of visual impairment due to diabetic macular oedema (DME) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Eylea	2571	Left eye, intravitreal injection of Eylea (Aflibercept) for the treatment of visual impairment due to macular oedema secondary to central retinal vein occlusion (CRVO) or branch retinal vein occlusion (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Eylea	2572	Right eye, intravitreal injection of Eylea (Aflibercept) for the treatment of visual impairment due to macular oedema secondary to central retinal vein occlusion (CRVO) or branch retinal vein occlusion (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Jetrea	2678	Left eye, intravitreal injection of Jetrea (Ocriplasmin) in adults for the treatment of vitreomacular traction (VMT), including when associated with macular hole of a diameter less than or equal to 400 microns. Claimable once only per lifetime (I.P.)	No	Independent Procedure, Side Room	For procedures 2678 and 2679 benefit is only payable where the intravitreal agent listed is used for the stated indication
Intravitreal Injections - Jetrea	2679	Right eye, intravitreal injection of Jetrea (Ocriplasmin) in adults for the treatment of vitreomacular traction (VMT), including when associated with macular hole of a diameter less than or equal to 400 microns. Claimable once only per lifetime (I.P.)	No	Independent Procedure, Side Room	For procedures 2678 and 2679 benefit is only payable where the intravitreal agent listed is used for the stated indication
Intravitreal Injections - Lucentis	2512	Left eye, intravitreal injection of Lucentis for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Lucentis	2513	Right eye, intravitreal injection of Lucentis for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Lucentis	2516	Left eye, intravitreal injection of Lucentis for the treatment of visual impairment due to diabetic macular oedema (DME) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Intravitreal Injections - Lucentis	2517	Right eye, intravitreal injection of Lucentis for the treatment of visual impairment due to diabetic macular oedema (DME) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Lucentis	2518	Left eye, intravitreal injection of Lucentis for the treatment of visual impairment due to macular oedema secondary to retinal vein occlusion (branch RVO or central RVO) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Lucentis	2519	Right eye, intravitreal injection of Lucentis for the treatment of visual impairment due to macular oedema secondary to retinal vein occlusion (branch RVO or central RVO) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Lucentis	669514	Bilateral, intravitreal injection of Lucentis for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Lucentis	669518	Bilateral, intravitreal injection of Lucentis for the treatment of visual impairment due to diabetic macular oedema (DME) (I.P.)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Lucentis	669520	Bilateral, intravitreal injection of Lucentis for the treatment of visual impairment due to macular oedema secondary to retinal vein occlusion (branch RVO or central RVO) (I.P.)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Ozurdex	2541	Intravitreal implantation of Ozurdex (Dexamethasone) for treatment of adult patients with macular oedema following either Branch Retinal Vein Occlusion (BRVO) or Central Retinal Vein Occlusion (CRVO) (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Ozurdex	2543	Intravitreal implantation of Ozurdex (Dexamethasone) for treatment of adult patients with inflammation of the posterior segment of the eye presenting as non-infectious uveitis (I.P.)	No	Independent Procedure, Side Room	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Ozurdex	669542	Right eye, intravitreal implantation of Ozurdex (Dexamethasone) for treatment of adult patients with macular oedema following either Branch Retinal Vein Occlusion (BRVO) or Central Retinal Vein Occlusion (CRVO) (I.P.)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Ozurdex	669543	Bilateral, intravitreal implantation of Ozurdex (Dexamethasone) for treatment of adult patients with macular oedema following either Branch Retinal Vein Occlusion (BRVO) or Central Retinal Vein Occlusion (CRVO) (I.P.)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Intravitreal Injections - Ozurdex	669544	Right eye, intravitreal implantation of Ozurdex (Dexamethasone) for treatment of adult patients with inflammation of the posterior segment of the eye presenting as non-infectious uveitis (I.P.)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Intravitreal Injections - Ozurdex	669545	Bilateral, intravitreal implantation of Ozurdex (Dexamethasone) for treatment of adult patients with inflammation of the posterior segment of the eye presenting as non-infectious uveitis (I.P.)	No	Side Room, Independent Procedure	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required If it is medically necessary for a consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the consultant Anaesthetist and submitted with the claim form Anaesthetist rate applies where full general anaesthetic is used If a full general anaesthetic is not administered, then code 399 for monitored anaesthesia applies
Iris, Ciliary Body and Choroid	2680	Division of anterior synechiae (I.P.)	No	Independent Procedure, Day Care	
Iris, Ciliary Body and Choroid	2685	Cyclodialysis	No		
Iris, Ciliary Body and Choroid	2696	Ciliary body destruction; cyclocryotherapy or diathermy	No	Day Care	
Iris, Ciliary Body and Choroid	2700	Goniotomy	No		
Iris, Ciliary Body and Choroid	2710	Iridectomy	No		
Iris, Ciliary Body and Choroid	2711	Pupil reconstruction post trauma, post surgery	No		
Iris, Ciliary Body and Choroid	2725	Iris tumour, removal	No		
Iris, Ciliary Body and Choroid	2726	Iris biopsy (I.P.)	No	Independent Procedure	
Iris, Ciliary Body and Choroid	2740	Trabeculectomy/ drainage procedure	No		1 Night Only
Iris, Ciliary Body and Choroid	2741	Laser trabeculoplasty, one or more treatments	No	Side Room	
Iris, Ciliary Body and Choroid	2742	Trabeculectomy and tubes, etc.	No	Day Care	
Iris, Ciliary Body and Choroid	2845	Local resection of ciliary body or choroidal tumour	No		
Lacrimal Apparatus	2750	Canaliculus repair with or without tube	No	Day Care	
Lacrimal Apparatus	2755	Dacryocystorhinostomy with or without tubes (I.P.)	No	Independent Procedure, Day Care	
Lacrimal Apparatus	2760	Lacrimal abscess, (dacrocystitis) incision	No	Side Room	

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Lacrimal Apparatus	2764	Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent (I.P.)	No	Independent Procedure, Day Care	
Lacrimal Apparatus	2766	Punctal closure with cautery or controller	No	Side Room	
Lacrimal Apparatus	2768	3 snip operation of lacrimal punctum	No	Side Room	
Lacrimal Apparatus	2769	Correction of everted punctum: cautery only	No	Side Room	
Lacrimal Apparatus	2770	Lacrimal sac excision (dacryocystectomy)	No		
Lacrimal Apparatus	2771	Lacrimal gland tumour excision	No		
Lacrimal Apparatus	2772	Conjunctivo - dacryocystorhinostomy with Lester Jones tube	No	Day Care	
Lacrimal Apparatus	608418	Dacryocystorhinostomy	No		
Laser/ Light Coagulation	2644	Argon or Diode laser or Xenon Arc, for treatment of retinal or choroidal disease, glaucoma, one or more treatments (I.P.)	No	Independent Procedure, Side Room	
Laser/ Light Coagulation	2806	Argon laser therapy for pan-retinal photocoagulation of diabetic retinopathy or central retinal vein occlusion (per course of therapy)	No	Side Room	
Lens	2779	Repositioning of intraocular lens prosthesis requiring an incision (I.P.)	No	Independent Procedure, Day Care	Prosthesis benefit is payable up to the value of monofocal lens only Benefit is not payable for elective refractive lens replacement surgery Should the Irish Life Health member elect to have a premium lens inserted at time of surgery, an additional charge for the cost of the lens above an agreed Irish Life Health contribution of €135 (which is included in the hospital charge) may be made by the hospital to the member In no circumstances may an additional professional fee be charged for such premium lens by a consultant who elects to be fully participating with Irish Life Health Benefit is not payable for lens extraction for prevention or treatment of glaucoma Benefit will be paid for one overnight stay in hospital when the surgery and procedure ground rules are met and in addition for patients with ASA I to III in the following exceptional circumstances: (a) patients with only one eye (b) co-existing eye disease e.g. glaucoma, uveitis (c) previous retinal surgery (d) eye injury causing corneal scarring (e) lens subluxation
Lens	2780	Intraocular lens insertion not associated with concurrent cataract removal secondary implant, for exchange lens associated with previous cataract surgery only (I.P.)	Yes	Independent Procedure, Day Care	Pre-authorisation required for patients under 60 years of age Prosthesis benefit is payable up to the value of monofocal lens only Benefit is not payable for elective refractive lens replacement surgery Should the Irish Life Health member elect to have a premium lens inserted at time of surgery, an additional charge for the cost of the lens above an agreed Irish Life Health contribution of €135 (which is included in the hospital charge) may be made by the hospital to the member In no circumstances may an additional professional fee be charged for such premium lens by a consultant who elects to be fully participating with Irish Life Health Benefit is not payable for lens extraction for prevention or treatment of glaucoma Benefit will be paid for one overnight stay in hospital when the surgery and procedure ground rules are met and in addition for patients with ASA I or III in the following exceptional circumstances: (a) Patients with only one eye (b) Co-existing eye disease e.g. glaucoma, uveitis (c) Previous retinal surgery (d) Eye injury causing corneal scarring (e) Lens subluxation

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Lens	2781	Artisan lens implantation for aphakia (I.P.)	Yes	Independent Procedure, Day Care	Procedure must be secondary to: (a) Congenital cataract surgery where the best corrected vision using contact lens is 6/12 or there are medical contraindications to the wearing of contact lenses (details of such contraindications to be provided) (b) Lens dislocation where the best corrected vision using contact lenses is 6/12 or worse or there are medical contraindications to the wearing of contact lenses (details of such contraindications to be provided) (c) Cataract surgery where it is certified that a secondary implant is medically necessary because of a displaced lens or capsule rupture (d) Cataract surgery following previous retinal detachment treated by vitrectomy
Lens	2785	Discission of secondary membranous cataract (opacified posterior lens capsule and/ or anterior hyaloid); stab incision technique (I.P.)	No	Independent Procedure	
Lens	2786	Revision or repair of operative wound of anterior segment of the eye, any type, early or late, major or minor procedure (I.P.)	No	Independent Procedure	
Lens	2795	Lens extraction	No	Day Care	Benefit is not payable for elective refractive lens replacement surgery Benefit will be paid for one overnight stay in hospital when the surgery and procedure ground rules are met and in addition for patients with ASA I or III, in the following exceptional circumstances: (a) Patients with only one eye (b) Co-existing eye disease e.g. glaucoma, uveitis (c) Previous retinal surgery (d) Eye injury causing corneal scarring (e) Lens subluxation
Lens	2802	Cataract extraction plus insertion of artificial lens (includes phacoemulsification, etc.) - Monitored anaesthesia care/ nerve block/ local/ regional anaesthesia	Yes	Day Care	Pre-authorisation required for patients under 60 years of age Prosthesis benefit is payable up to the value of monofocal lens only Benefit is not payable for elective refractive lens replacement surgery Should the Irish Life Health member elect to have a premium lens inserted at time of surgery, an additional charge for the cost of the lens above an agreed Irish Life Health contribution of €135 (which is included in the hospital charge) may be made by the hospital to the member In no circumstances may an additional professional fee be charged for such premium lens by a consultant who elects to be fully participating with Irish Life Health Benefit is not payable for lens extraction for prevention or treatment of glaucoma Benefit will be paid for one overnight stay in hospital when the surgery and procedure ground rules are met and in addition for patients with ASA I or III in the following exceptional circumstances (a) Patients with only one eye (b) Co-existing eye disease e.g. glaucoma, uveitis (c) Previous retinal surgery (d) Eye injury causing corneal scarring (e) Lens subluxation If a second procedure is performed within 60 days of the initial procedure, on the same eye, benefit at the rate of 50% only will be paid
Lens	2803	Cataract extraction plus insertion of artificial lens (includes phacoemulsification, etc.) - General anaesthesia	Yes	Day Care	Pre-authorisation required for patients under 60 years of age Prosthesis benefit is payable up to the value of monofocal lens only Benefit is not payable for elective refractive lens replacement surgery Should the Irish Life Health member elect to have a premium lens inserted at time of surgery, an additional charge for the cost of the lens above an agreed Irish Life Health contribution of €135 (which is included in the hospital charge) may be made by the hospital to the member In no circumstances may an additional professional fee be charged for such premium lens by a consultant who elects to be fully participating with Irish Life Health Benefit is not payable for lens extraction for prevention or treatment of glaucoma Benefit will be paid for one overnight stay in hospital when the surgery and procedure ground rules are met and in addition for patients with ASA I or III in the following exceptional circumstances: (a) Patients with only one eye (b) Co-existing eye disease e.g. glaucoma, uveitis (c) Previous retinal surgery (d) Eye injury causing corneal scarring (e) Lens subluxation If a second procedure is performed within 60 days of the initial procedure, on the same eye, benefit at the rate of 50% only will be paid

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Lens	2804	Cataract extraction plus insertion of artificial lens (includes phacoemulsification, etc.) Children up to 16 years of age.	No	Day Care	Prosthesis benefit is payable up to the value of monofocal lens only Benefit is not payable for elective refractive lens replacement surgery Should the Irish Life Health member elect to have a premium lens inserted at time of surgery, an additional charge for the cost of the lens above an agreed Irish Life Health contribution of €135 (which is included in the hospital charge) may be made by the hospital to the member In no circumstances may an additional professional fee be charged for such premium lens by a consultant who elects to be fully participating with Irish Life Health Benefit is not payable for lens extraction for prevention or treatment of glaucoma Benefit will be paid for one overnight stay in hospital when the surgery and procedure ground rules are met and in addition for patients with ASA I or III in the following exceptional circumstances (a) Patients with only one eye (b) Co-existing eye disease e.g. glaucoma, uveitis (c) Previous retinal surgery (d) Eye injury causing corneal scarring (e) Lens subluxation If a second procedure is performed within 60 days of the initial procedure, benefit at the rate of 50% only will be paid
Lens	668261	Left and right eye, same day cataract extraction plus insertion of artificial lens (includes phacoemulsification, etc.) - monitored anaesthesia care	Yes	Day Care	Pre-authorisation required for patients under 60 years of age Prosthesis benefit is payable up to the value of monofocal lens only Benefit is not payable for elective refractive lens replacement surgery Should the Irish Life Health member elect to have a premium lens inserted at time of surgery, an additional charge for the cost of the lens above an agreed Irish Life Health contribution of €135 (which is included in the hospital charge) may be made by the hospital to the member In no circumstances may an additional professional fee be charged for such premium lens by a consultant who elects to be fully participating with Irish Life Health Benefit is not payable for lens extraction for prevention or treatment of glaucoma Benefit will be paid for one overnight stay in hospital when the surgery and procedure ground rules are met and in addition for patients with ASA I or III in the following exceptional circumstances: (a) Patients with only one eye (b) Co-existing eye disease e.g. glaucoma, uveitis (c) Previous retinal surgery (d) Eye injury causing corneal scarring (e) Lens subluxation If a second procedure is performed within 60 days of the initial procedure, benefit at the rate of 50% only will be paid
Lens	668262	Left and right eye, same day cataract extraction plus insertion of artificial lens (includes phacoemulsification, etc.) - general anaesthesia	No	Day Care	Pre-authorisation required for patients under 60 years of age Prosthesis benefit is payable up to the value of monofocal lens only Benefit is not payable for elective refractive lens replacement surgery Should the Irish Life Health member elect to have a premium lens inserted at time of surgery, an additional charge for the cost of the lens above an agreed Irish Life Health contribution of €135 (which is included in the hospital charge) may be made by the hospital to the member In no circumstances may an additional professional fee be charged for such premium lens by a consultant who elects to be fully participating with Irish Life Health Benefit is not payable for lens extraction for prevention or treatment of glaucoma Benefit will be paid for one overnight stay in hospital when the surgery and procedure ground rules are met and in addition for patients with ASA I or III in the following exceptional circumstances (a) Patients with only one eye (b) Co-existing eye disease e.g. glaucoma, uveitis (c) Previous retinal surgery (d) Eye injury causing corneal scarring (e) Lens subluxation If a second procedure is performed within 60 days of the initial procedure, benefit at the rate of 50% only will be paid
Ocular Muscles	2870	Initial Strabismus, squint operation, horizontal, vertical or oblique	No	Day Care	
Ocular Muscles	2871	Transposition surgery	No		
Ocular Muscles	2873	Botulinum toxin injection to extraocular muscles	No	Side Room	
Ocular Muscles	2874	Muscle biopsy (I.P.)	No	Independent Procedure	

OPHTHALMOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Ocular Muscles	657883	Subsequent strabismus/ squint operation - horizontal, vertical or oblique	No	Day Care	
Orbit	2890	Orbit, exenteration of	No		
Orbit	2895	Orbit, exploration of, including biopsy	No	Day Care	
Orbit	2900	Orbit, removal of foreign body from	No		
Orbit	2905	Orbit, removal of tumour from (Kronlein's operation)	No		
Orbit	2910	Orbit, repair of fracture of	No	Day Care	
Orbit	2911	Orbitotomy	No		
Orbit	2912	Transnasal wiring	No		
Orbit	2915	Orbit, repair of fracture of, with plastic implant	No		
Posterior Segment	2506	Removal of silicone oil not associated with retinal repair at same operative session	No	Day Care	
Posterior Segment	2665	Prophylaxis of retinal detachment (e.g. retinal break, lattice degeneration), one or more sessions cryotherapy, diathermy, or photocoagulation/ laser	No	Side Room	Codes 2665, 2675 and 2676 cannot be combined for benefit payment purposes
Posterior Segment	2675	Repair of retinal detachment, retinopexy with scleral buckling, scleral resection or scleral implant, etc. (for diathermy, cryotherapy or photocoagulation use code 2665)	No		Codes 2665, 2675 and 2676 cannot be combined for benefit payment purposes
Posterior Segment	2676	Vitrectomy - including prophylaxis for retinal detachment (e.g. retinal break, lattice degeneration), one or more sessions cryotherapy, diathermy, or photocoagulation/ laser	No		Codes 2665, 2675 and 2676 cannot be combined for benefit payment purposes
Posterior Segment	2677	Complex repair of retinal detachment, retionopexy with scleral buckling, scleral resection or scleral implant, includes vitrectomy, claimable only when membrane dissection is also involved - including Prophylaxis of retinal detachment (e.g. retinal break, lattice degeneration), one or more sessions cryotherapy, diathermy, or photocoagulation/ laser (I.P.)	No	Independent Procedure	
Posterior Segment	2880	Examination of eye under general anaesthetic (I.P.)	No	Independent Procedure, Diagnostic, Day Care	

ORTHOPAEDICS

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Amputation	3140	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure (use also for traumatic amputations)	No		
Amputation	3145	Amputation of two or more fingers	No		

ORTHOPAEDICS

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Amputation	3280	Amputation through forearm	No		
Amputation	3415	Amputation through arm	No		
Amputation	3464	Fore quarter amputation	No		
Amputation	3645	Above knee amputation	No		
Amputation	3690	Hind quarter amputation	No		
Amputation	3790	Below knee amputation	No		
Amputation	4255	Trans metatarsal amputation of foot	No		
Amputation	4260	Trans metatarsal amputation of one toe	No		
Amputation	4261	Trans metatarsal amputation of two or more toes	No		
Amputation	4330	Trimming of stump following amputation of limb	No		
Ankle	3955	Arthrodesis of ankle joint	No		
Ankle	3956	Arthroscopy, ankle, with or without removal of loose body or foreign body, with or without synovectomy, debridement (I.P.)	No	Independent Procedure, Day Care	
Ankle	3961	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/ or tibia, including drilling of the defect (I.P.)	No	Independent Procedure	1 Night Only
Ankle	3962	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy) (I.P.)	No	Independent Procedure	
Ankle	3963	Arthroscopy, subtalar joint, surgical, with subtalar arthrodesis (I.P.)	No	Independent Procedure	
Ankle	3965	Fracture of medial or lateral malleolus (1st degree Pott's fracture), internal fixation of	No		
Ankle	3970	Fracture of posterior malleolus without fracture of other malleolus, internal fixation of	No		
Ankle	3971	Open treatment of bimalleolar ankle fracture, with or without internal fixation	No		
Ankle	3972	Fracture of trimalleolar ankle fracture with or without internal or external fixation, medial and/ or lateral malleolus; with fixation of posterior lip	No		
Ankle	3975	Fracture, Pott's, closed reduction of	No		
Ankle	3976	Closed reduction manipulation of dislocated ankle joint, with or without percutaneous skeletal fixation such as pins	No		
Ankle	3980	Synovectomy and debridement	No	Day Care	
Ankle	3985	Synovial biopsy, ankle	No	Diagnostic, Day Care	

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Ankle	3986	Talar fracture, open reduction and internal fixation of	No		
Ankle	3990	Tendon, achilles, elongation of	No		
Ankle	3995	Tendon, achilles, repair of	No		
Ankle	4000	Tendon transplants about the ankle joint and foot (multiple)	No		
Ankle	4005	Tendon transplants about the ankle joint and foot (single)	No		
Ankle	4010	Traumatic fracture and dislocation, open reduction of	No		
Ankle	4015	Unstable ankle, Watson Jones operation for	No		
Arthrocentesis/ Injections	4322	Arthrocentesis, children aged under 12; less than 4 injections at the same session to knee, wrist, elbow, ankle and/ or shoulder joint (I.P.)	No	Independent Procedure, Day Care	
Arthrocentesis/ Injections	4323	Arthrocentesis, children aged under 12; 4 or more injections at the same session to knee, wrist, elbow, ankle and/ or shoulder joint (I.P.)	No	Independent Procedure, Day Care	
Arthrocentesis/ Injections	4324	Arthrocentesis, children aged under 12; less than 4 injections at the same session, using image guidance, to hip, finger and/ or toe joint (I.P.)	No	Independent Procedure, Day Care	
Arthrocentesis/ Injections	4326	Arthrocentesis, children aged under 12; 4 or more injections at the same session, using image guidance, to hip, finger and/ or toe joints (I.P.)	No	Independent Procedure, Day Care	
Congenital Talipes Equinovarus	4019	Astragalectomy	No		
Congenital Talipes Equinovarus	4020	Dwyer's valgus osteotomy	No		
Congenital Talipes Equinovarus	4025	Manipulation and plaster fixation	No	Day Care	
Congenital Talipes Equinovarus	4035	Rotation osteotomy of tibia	No		
Congenital Talipes Equinovarus	4040	Soft tissue release	No		
Congenital Talipes Equinovarus	4045	Tarsal osteotomy	No		
Congenital Talipes Equinovarus	4050	Tendon transplant, single	No		
Congenital Talipes Equinovarus	4051	Tendon transplant, multiple	No		
External Fixation	4305	Partial excision of osteomyelitic bone (e.g. sequestrectomy, diaphysectomy), long bones, with or without bone grafting (not for bone biopsy) (I.P.)	No	Independent Procedure	

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
External Fixation	4306	Application of uniplane external fixation system, for the treatment of complex peri-articular and intra-articular fractures, or non unions and correcting deformity following malunited fractures, unilateral (e.g. Extremity, pelvis)	No		
External Fixation	4307	Application of multiplane external fixation system, for the treatment of complex peri-articular and intra-articular fractures, or non unions and correcting deformity following malunited fractures, unilateral (e.g. extremity, pelvis)	No		
External Fixation	4308	Adjustment or revision of (uniplane or multiplane) external fixation system requiring general anaesthetic	No		
External Fixation	4309	External fixation system (uniplane or multiplane as in procedure codes 4306 and 4307) removal under general anaesthetic	No	Day Care	
Foot	4060	Arthrodesis of all inter phalangeal joints (Lambrinudi), unilateral	No		
Foot	4065	Arthrodesis of all inter phalangeal joints (Lambrinudi), bilateral	No		
Foot	4070	Arthrodesis of first metatarso phalangeal joint (I.P.)	No	Independent Procedure	1 Night Only
Foot	4075	Arthrodesis triple, in all its forms	No		
Foot	4080	Arthrodesis, pantalar	No		
Foot	4085	Claw foot (Steindlar), muscle stripping, operations for	No		
Foot	4090	Exostosis of first metatarsal, unilateral, removal of	No	Day Care	This code cannot be charged in conjunction with codes 4095, 4182, 4184
Foot	4095	Exostosis of first metatarsal, bilateral, removal of	No		This code cannot be charged in conjunction with codes 4090, 4182, 4184
Foot	4100	Flat foot involving joint fusion, operation for	No		
Foot	4101	Flexor tenotomy, single (foot)	No	Day Care	
Foot	4102	Flexor tenotomy, multiple (foot)	No	Day Care	
Foot	4103	Fracture of hind foot, internal fixation, unilateral	No		
Foot	4104	Fracture of hind foot, internal fixation, bilateral	No		
Foot	4105	Fracture of phalanges and/ or metatarsals, closed reduction of (I.P.)	No	Independent Procedure, Day Care	
Foot	4106	Open treatment (hind foot) of calcaneal or talus fracture with or without internal or external fixation	No		
Foot	4107	Percutaneous skeletal fixation of metatarsal fracture with manipulation	No		
Foot	4108	Open treatment of metatarsal fracture, with or without internal or external fixation	No		
Foot	4110	Fracture of phalanx and/ or metatarsal, single, internal fixation of	No		This code cannot be charged in conjunction with code 4135

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Foot	4115	Fracture of phalanges and/ or metatarsals, multiple, internal fixation of	No		
Foot	4120	Ganglion of foot, excision of	No	Day Care	
Foot	4125	Hallux valgus and follow up, other than simple removal of exostosis, unilateral operation for	No		1 Night Only
Foot	4130	Hallux valgus and follow up, other than simple removal of exostosis, bilateral, operation for	No		
Foot	4135	Hammertoe, correction of, single toe	No	Day Care	This code cannot be charged in conjunction with code 4110
Foot	4140	Hammertoe, bilateral, correction of	No		1 Night Only
Foot	4141	Hammertoe, correction of, three or more toes, unilateral or bilateral (I.P.)	No	Independent Procedure	
Foot	4145	Grice's operation, subtalar bone block	No		
Foot	4161	Initial pledget insertion for infected ingrowing toe nail, under general anaesthetic, in children under 16 years of age (I.P.)	No	Independent Procedure, Day Care	
Foot	4162	Tarsal tunnel release (posterior tibial nerve decompression)	No		
Foot	4170	Laprau's operation to correct position of toe	No		
Foot	4175	Metatarsal heads, excision of all, and plastic correction of sole, unilateral	No		
Foot	4180	Metatarsal heads, excision of all, and plastic correction of sole, bilateral, (Hoffman's)	No		
Foot	4182	Metatarsal osteotomy, unilateral	No	Day Care	Where these procedures are done in an out-patient setting there is an enhanced surgeon fee - see Minor Procedure Schedule
Foot	4183	Metatarsal osteotomies, bilateral	No		1 Night Only
Foot	4184	Chevron osteotomy, single	No		1 Night Only This code cannot be charged in conjunction with code 4090, 4095, 4182
Foot	4185	Os calcis, osteotomy of (Dwyer)	No		
Foot	4190	Os calcis and bursa, posterior exostosis of, unilateral removal of	No		
Foot	4195	Os calcis and bursa, posterior exostosis of, bilateral, removal of	No		
Foot	4200	Plantar fascia, excision or division of, unilateral	No	Day Care	
Foot	4205	Plantar fascia, excision or division of, bilateral	No		
Foot	4215	Stamm's operation, unilateral	No		
Foot	4220	Stamm's operation, bilateral	No		
Foot	4225	Talectomy	No		
Foot	4230	Tarsal osteotomy	No		

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Foot	4235	Tendon transplantation about the foot, multiple	No		
Foot	4240	Tendon transplantation about the foot, single	No		
Foot	4245	Tendon transplantation, flexor and extensor all toes, unilateral	No		
Foot	4250	Tendon transplantation, flexor and extensor all toes, bilateral	No		
Forearm and Elbow	3285	Annular ligament, repair of	No		
Forearm and Elbow	3290	Anterior capsulotomy and excision (myositis ossificans)	No		
Forearm and Elbow	3295	Arthrodesis of elbow joint (I.P.)	No	Independent Procedure	
Forearm and Elbow	3296	Arthroscopy, elbow, diagnostic, with or without synovial biopsy, removal of loose body or foreign body, synovectomy, debridement (I.P.)	No	Independent Procedure, Day Care	
Forearm and Elbow	3297	Arthroscopy, elbow, surgical; includes extensive debridement to all parts of the elbow joint, with complete synovectomy (osteocapsular arthroplasty) (I.P.)	No	Independent Procedure	
Forearm and Elbow	3315	Drainage of elbow joint	No		
Forearm and Elbow	3316	External fixation, upper limb	No		
Forearm and Elbow	3320	Fracture forearm (complete), closed reduction and plaster of paris	No	Day Care	
Forearm and Elbow	3325	Fracture forearm (greenstick), closed reduction and plaster of paris	No		
Forearm and Elbow	3330	Fracture about elbow, closed manipulation of	No		
Forearm and Elbow	3335	Fracture dislocation, open reduction of (forearm/ elbow)	No		
Forearm and Elbow	3340	Fracture of forearm bones, open reduction of	No		
Forearm and Elbow	3341	Open reduction, internal fixation and bone grafting (forearm/ elbow)	No		
Forearm and Elbow	3345	Fracture of lateral condyle, open reduction of	No		
Forearm and Elbow	3350	Fracture of medial condyle, open reduction of	No		
Forearm and Elbow	3355	Fracture (supracondylar), closed reduction of	No		
Forearm and Elbow	3360	Fracture, olecranon, screwing of	No		
Forearm and Elbow	3365	Closed treatment of elbow dislocation (I.P.)	No	Independent Procedure	
Forearm and Elbow	3370	Nerve, ulnar, transplant	No		
Forearm and Elbow	3375	Olecranon bursa, removal of	No	Day Care	
Forearm and Elbow	3380	Radius, excision of head of	No		
Forearm and Elbow	3381	Silastic interposition of radial head	No		
Forearm and Elbow	3385	Open synovectomy of elbow joint	No		

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Forearm and Elbow	3390	Tendon transplants about the elbow	No		
Forearm and Elbow	3395	Tendon sheaths, removal of, in forearm	No	Day Care	
Forearm and Elbow	3400	Tennis elbow, advancement of extensor muscles	No	Day Care	
Forearm and Elbow	3406	Decompression fasciotomy, forearm and/ or wrist flexor or extensor compartment; with or without debridement of non-viable muscle and/ or nerve	No		
Hand	3035	Abscess or infected tendon sheath of palmar spaces, drainage of	No		
Hand	3039	Debridement/ synovectomy of metacarpophalangeal and/ or proximal interphalangeal joints, more than two joints	No		
Hand	3040	Arthrodesis of joint (I.P.)	No	Independent Procedure, Day Care	
Hand	3041	Arthrodesis of the carpometacarpal joint of the thumb using bone graft	No		
Hand	3070	Bursectomy	No		
Hand	3075	Benign bone tumours, multiple, excision of, with or without bone graft	No		
Hand	3080	Benign bone tumour, single, excision of, with or without bone graft	No		
Hand	3085	Exostosis, excision of	No	Day Care	
Hand	3095	Fracture of phalanges and/ or metacarpals, closed reduction (I.P.)	No	Independent Procedure, Day Care	
Hand	3100	Fracture of phalanx, single, internal fixation	No	Day Care	
Hand	3105	Fracture of phalanges, multiple, internal fixation	No		
Hand	3106	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation when performed, for complex crush injuries requiring bone reconstruction	No		
Hand	3110	Ganglion or mucous cyst of hand, surgical removal of (includes repair) (I.P.)	No	Independent Procedure, Side Room	
Hand	3115	Manipulation for treatment of dislocation of metacarpophalangeal joint (I.P.)	No	Independent Procedure, Side Room	
Hand	3125	Nails, removal of all	No	Side Room	Where these procedures are done in an out-patient setting there is an enhanced surgeon fee - see Minor Procedure Schedule
Hand	3126	Debridement and repair of nail bed, for simple crush injuries	No	Side Room	
Hand	3135	Synovioma, excision of	No	Day Care	
Hand	3136	Tendon repair, flexor-double (hand)	No		

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Hand	3150	Trigger finger, correction of	No	Day Care	
Hand	4061	Arthroscopy of metacarpophalangeal joint, with or without biopsy (I.P.)	No	Independent Procedure	1 Night Only
Hand	4062	Debridement/ synovectomy of , metacarpophalangeal and/ or proximal interphalangeal joint, one or two joints (I.P.)	No	Independent Procedure	1 Night Only
Hand	4063	Arthroscopic repair of displaced MCP ulnar collateral ligament (e.g. Stener lesion) (I.P.)	No	Independent Procedure	
Hip and Femur	3630	Acetabuloplasty, shelf operation	No		
Hip and Femur	3631	Internal fixation of acetabular fractures	No		
Hip and Femur	3635	Acute dislocation, manipulation for	No		
Hip and Femur	3636	Congenital dislocation of hip, examination under anaesthetic (EUA) and plaster of paris (POP) (I.P.)	No	Independent Procedure, Day Care	
Hip and Femur	3640	Acute dislocation or fracture dislocation, open reduction, hip/ femur	No		
Hip and Femur	3650	Arthrodesis, hip/ femur	No		
Hip and Femur	3654	Hip arthroscopy, with acetabuloplasty (i.e. treatment of pincer lesion) includes labral repair and loose body removal if performed	No		1 Night Only
Hip and Femur	3656	Arthroscopy, hip, diagnostic; with or without synovial biopsy (separate procedure) (I.P.)	No	Independent Procedure	1 Night Only
Hip and Femur	3657	Arthroscopy, hip, surgical; with synovectomy (I.P.)	No	Independent Procedure	1 Night Only
Hip and Femur	3658	Hip arthroscopy, with femoroplasty (i.e. treatment of cam lesion) includes loose or foreign body removal if performed	No		1 Night Only
Hip and Femur	3659	Hip arthroscopy, with removal of loose/ foreign body, debridement/ shaving of articular cartilage (chondroplasty), abrasion arthroplasty and/ or resection of labrum (I.P.)	No	Independent Procedure	1 Night Only
Hip and Femur	3665	Arthrotomy for loose body	No		
Hip and Femur	3675	Corrective osteotomy with or without internal fixation	No		
Hip and Femur	3680	Curetting of greater trochanter and bursectomy	No		
Hip and Femur	3695	Drainage of hip joint for acute infection (I.P.)	No	Independent Procedure	
Hip and Femur	3700	Exostosis of femoral neck in slipped femoral epiphysis, excision of (for patients < 18 years only) (I.P.)	No	Independent Procedure	
Hip and Femur	3705	Femoral condyle, osteotomy of (I.P.)	No	Independent Procedure	
Hip and Femur	3709	Fractured femur, hemiarthroplasty	No		
Hip and Femur	3710	Fractured shaft of femur, open reduction, with internal fixation	No		

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Hip and Femur	3715	Fractured shaft of femur, closed reduction, with traction	No		
Hip and Femur	3720	Fractured femur (supracondylar) open reduction of	No		
Hip and Femur	3723	Fractured shaft of femur, closed intramedullary nailing	No		
Hip and Femur	3724	Fractured shaft of femur closed intramedullary, interlocking nail	No		
Hip and Femur	3725	Fracture of neck of femur, intramedullary nail fixation of	No		
Hip and Femur	3729	Repair, non union or malunion, femur, distal to head and neck with iliac or other autogenous bone graft (includes obtaining graft)	No		
Hip and Femur	3730	Fracture of femur (per trochanteric or introchanteric) intramedullary nail fixation of	No		
Hip and Femur	3731	Open treatment of anterior ring fracture and/ or dislocation with internal fixation, (includes pubic symphysis and/ or rami)	No		
Hip and Femur	3732	Open treatment of posterior ring fracture and/ or dislocation with internal fixation, (includes ilium, sacro-iliac joint and/ or sacrum)	No		
Hip and Femur	3733	Pelvic fracture, external fixation	No		
Hip and Femur	3735	Hip deformity, soft tissue operations for correction of (I.P.)	No	Independent Procedure	
Hip and Femur	3745	Manipulation of hip, closed, requiring general anaesthetic	No	Day Care	
Hip and Femur	3750	Open reduction and/ or rotation osteotomy	No		
Hip and Femur	3751	Open reduction, pelvic osteotomy and femoral shortening	No		
Hip and Femur	3755	Pelvic osteotomy	No		
Hip and Femur	3756	Modified innominate osteotomy including bone graft	No		
Hip and Femur	3760	Pseudoarthroplasty of hip (Girdlestone operation)	No		
Hip and Femur	3765	Slipped femoral epiphysis, intramedullary nail, fixation of	No		
Hip and Femur	3770	Slipped femoral epiphysis, lower end, stapling of	No		
Hip and Femur	3775	Synovectomy of hip joint and debridement (I.P.)	No	Independent Procedure	
Hip and Femur	3785	Transplantation of psoas muscle to greater trochanter (Mustard's or Sherrard's operation)	No		
Humerus and Shoulder	3401	Arthroscopy, shoulder, surgical, with lysis and resection of adhesions, and/ or removal of loose body or foreign body, and/ or synovectomy or bursectomy, and/ or debridement with or without manipulation	No	Not claimable with codes 3402, 3408, 3411 or 3415	
Humerus and Shoulder	3402	Arthroscopic suture capsulorrhaphy for anterior shoulder instability	No	Not claimable with codes 3401, 3408, 3411 or 3415	

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Humerus and Shoulder	3403	Arthroscopy, shoulder, diagnostic with or without synovial biopsy (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Humerus and Shoulder	3404	Acromioplasty	No		
Humerus and Shoulder	3405	Open acromio-clavicular joint, excision of	No		
Humerus and Shoulder	3407	Arthroscopy, shoulder, surgical; repair of SLAP lesion (I.P.)	No	Independent Procedure	
Humerus and Shoulder	3408	Arthroscopy, shoulder, surgical; with rotator cuff repair	No		1 Night Only Not claimable with codes 3401, 3402, 3411, 3414 or 3416
Humerus and Shoulder	3410	Acromio-clavicular joint, open reduction of	No		
Humerus and Shoulder	3411	Arthroscopic subacromial decompression, includes diagnostic arthroscopy (code 3403)	No		1 Night Only Not claimable with codes 3401, 3403, 3408, 3412, 3413, 3416 or 3417
Humerus and Shoulder	3412	Arthroscopic excision outer end of clavicle	No	Not claimable with codes 3408, 3411 or 3413	
Humerus and Shoulder	3413	Arthroscopic excision outer end of clavicle/ subacromial decompression, includes diagnostic arthroscopy (Code 3403)	No		1 Night Only Not claimable with codes 3403, 3408, 3411, 3412, 3416 or 238067
Humerus and Shoulder	3414	Arthroscopy, shoulder, surgical; biceps tenodesis	No	Not claimable with code 3401	
Humerus and Shoulder	3416	Arthroscopy, shoulder, surgical; with rotator cuff repair and decompression of subacromial space by bursectomy and/ or acromioplasty	No	Not claimable with codes 3401, 3402, 3408 or 3411	
Humerus and Shoulder	3420	Arthrodesis, humerus/ shoulder	No		
Humerus and Shoulder	3430	Biopsy, synovial, humerus/ shoulder (I.P.)	No	Independent Procedure, Diagnostic	
Humerus and Shoulder	3435	Capsulotomy (acute capsulitis)	No		
Humerus and Shoulder	3440	Disarticulation, humerus/ shoulder (I.P.)	No		
Humerus and Shoulder	3445	Dislocation, open reduction of, humerus/ shoulder (I.P.)	No	Independent Procedure	
Humerus and Shoulder	3450	Dislocation, acute, manipulation under general anaesthetic, humerus/ shoulder	No	Day Care	

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Humerus and Shoulder	3455	Dislocation, open recurrent, operation for, humerus/ shoulder (I.P.)	No	Independent Procedure	
Humerus and Shoulder	3456	Latarjet procedure including diagnostic arthroscopy (I.P.)	No	Independent Procedure	
Humerus and Shoulder	3457	Open shoulder stabilisation (labral/ capsular repair) for multidirectional instability including examination under anaesthesia (EUA) and arthroscopy (I.P.)	No	Independent Procedure	
Humerus and Shoulder	3465	Fractured clavicle, closed reduction of	No		
Humerus and Shoulder	3470	Fractured clavicle, open reduction of	No		
Humerus and Shoulder	3471	Open reduction internal fixation and bone grafting non union of a fracture of the clavicle	No		
Humerus and Shoulder	3475	Fractured humerus, open reduction with internal fixation	No		
Humerus and Shoulder	3480	Fractured humerus, open reduction and bone graft	No		
Humerus and Shoulder	3485	Fractured humerus, closed reduction of	No		
Humerus and Shoulder	3495	Manipulation of shoulder joint under general anaesthetic (I.P.)	No	Independent Procedure, Day Care	
Humerus and Shoulder	3500	Open repair of capsule (in rotator cuff injuries) humerus/ shoulder (I.P.)	No	Independent Procedure	
Humerus and Shoulder	3510	Subacromial bursectomy (I.P.)	No	Independent Procedure	
Humerus and Shoulder	3515	Tendon transplant about shoulder	No		
Humerus and Shoulder	234936	Superior capsular reconstruction (I.P.)	No	Independent Procedure	
Humerus and Shoulder	238067	Shoulder arthroscopy (glenohumeral) with additional decompression of subacromial space via different port, lysis/ resection of adhesions, removal of loose/ foreign body, synovectomy +/- debridement (I.P.)	No	Independent Procedure	1 Night Only
Knee and Lower Leg	3795	Arthrodesis, knee	No		
Knee and Lower Leg	3815	Baker's cyst, excision of	No	Day Care	
Knee and Lower Leg	3816	Bone transportation	No		
Knee and Lower Leg	3817	Removal of fixator device, tibia	No	Day Care	
Knee and Lower Leg	3818	Arthroscopy of knee, surgical; with lateral release	No	Day Care	Confirmation/ proof that the member has undergone physiotherapy intervention pre-surgery is to be provided Alternatively surgical rationale must be stated on the claim form

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Knee and Lower Leg	3819	Arthroscopy, knee, diagnostic, with or without synovial biopsy (I.P.)	No	Independent Procedure, Diagnostic, Day Care	Confirmation/ proof that the member has undergone physiotherapy intervention pre-surgery is to be provided Alternatively surgical rationale must be stated on the claim form
Knee and Lower Leg	3820	Cartilage(s), removal of, knee	No	Day Care	Confirmation/ proof that the member has undergone physiotherapy intervention pre-surgery is to be provided Alternatively surgical rationale must be stated on the claim form
Knee and Lower Leg	3821	Arthroscopy and removal of cartilage, knee, with meniscectomy (medial or lateral including meniscal shaving) including debridement/ shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed (I.P.)	No	Independent Procedure, Day Care	Cannot be charged in conjunction with code 3839 Confirmation/ proof that the member has undergone physiotherapy intervention pre-surgery is to be provided Alternatively surgical rationale must be stated on the claim form
Knee and Lower Leg	3822	Arthroscopy of the knee for removal of loose body or foreign body, synovectomy, debridement (I.P.)	No	Independent Procedure, Day Care	Confirmation/ proof that the member has undergone physiotherapy intervention pre-surgery is to be provided Alternatively surgical rationale must be stated on the claim form
Knee and Lower Leg	3825	Corrective osteotomy of tibia in region of knee	No		
Knee and Lower Leg	3830	Corrective osteotomy of tibia in region of ankle	No		
Knee and Lower Leg	3831	Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g. mosaicplasty) (includes harvesting of the autograft(s)) (I.P.)	No	Independent Procedure	Confirmation/ proof that the member has undergone physiotherapy intervention pre-surgery is to be provided Alternatively surgical rationale must be stated on the claim form
Knee and Lower Leg	3832	Arthroscopy, knee, surgical; osteochondral allograft(s) (e.g. mosaicplasty) (includes harvesting of the autograft(s)) (I.P.)	No	Independent Procedure	Confirmation/ proof that the member has undergone physiotherapy intervention pre-surgery is to be provided Alternatively surgical rationale must be stated on the claim form
Knee and Lower Leg	3833	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion) medical or lateral) (I.P.). Patient must have undergone a 6 weeks course of Physiotherapy	No	Independent Procedure	1 Night Only Confirmation/ proof that the member has undergone physiotherapy intervention pre-surgery is to be provided Alternatively surgical rationale must be stated on the claim form
Knee and Lower Leg	3834	Arthroscopy, knee, surgical; for infection, lavage and drainage (I.P.)	No	Independent Procedure	
Knee and Lower Leg	3835	Cruciate ligaments, repair	No		
Knee and Lower Leg	3836	Arthroscopic anterior cruciate ligament reconstruction	No		1 Night Only
Knee and Lower Leg	3837	Arthroscopic anterior cruciate ligament reconstruction and meniscectomy (I.P.)	No	Independent Procedure	1 Night Only
Knee and Lower Leg	3838	Arthroscopic anterior cruciate ligament reconstruction and meniscal repair	No		1 Night Only
Knee and Lower Leg	3839	Arthroscopy of knee with meniscus repair by suture fixation (medial and/ or lateral)	No	Day Care	Cannot be charged in conjunction with code 3821 Confirmation/ proof that the member has undergone physiotherapy intervention pre-surgery is to be provided Alternatively surgical rationale must be stated on the claim form
Knee and Lower Leg	3840	Drainage of joint in acute infection	No		
Knee and Lower Leg	3845	Exploration of joint, knee/ lower leg	No		
Knee and Lower Leg	3850	Fixed flexion of knee, soft tissue operations for	No		
Knee and Lower Leg	3855	Fracture dislocation of knee joint, operations for	No		
Knee and Lower Leg	3860	Fracture of tibia (condylar) open reduction of	No		

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Knee and Lower Leg	3865	Fracture of tibial shaft, open reduction and internal fixation	No		
Knee and Lower Leg	3870	Fracture of tibial shaft, closed reduction of	No		
Knee and Lower Leg	3871	Fracture of tibial shaft, closed intra-medullary, interlocking nail	No		
Knee and Lower Leg	3872	Arthroscopically aided treatment of intercondylar spine(s) and/ or tuberosity fracture(s) of the knee, with or without manipulation; without external fixation (includes arthroscopy) (I.P.)	No	Independent Procedure	
Knee and Lower Leg	3873	Arthroscopically aided treatment of intercondylar spine(s) and/ or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy) (I.P.)	No	Independent Procedure	
Knee and Lower Leg	3874	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation when performed (includes arthroscopy) (I.P.)	No	Independent Procedure	
Knee and Lower Leg	3876	Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, includes internal fixation, when performed (includes arthroscopy) (I.P.)	No	Independent Procedure	
Knee and Lower Leg	3880	Lateral ligaments, repair	No		
Knee and Lower Leg	3885	Manipulation under general anaesthetic, knee/ lower leg (I.P.)	No	Independent Procedure	
Knee and Lower Leg	3890	Osteochondritis dissecans, Smillies operation for	No		
Knee and Lower Leg	3895	Patellectomy or open reduction of fractured patella	No		
Knee and Lower Leg	3896	Resurfacing of patella	No		
Knee and Lower Leg	3900	Pre patellar bursa, removal of	No	Day Care	
Knee and Lower Leg	3905	Plication of vastii, etc.	No		
Knee and Lower Leg	3912	Reconstruction of knee, (anterior cruciate)	No		
Knee and Lower Leg	3915	Quadriceps mechanism, repair	No		
Knee and Lower Leg	3920	Slipped epiphysis, stapling of, or epiphysiodesis	No		
Knee and Lower Leg	3925	Slipped epiphysis (tibial and femoral combined), stapling of, or epiphysiodesis	No		
Knee and Lower Leg	3930	Slipped epiphyses (bilateral tibial), stapling of	No		
Knee and Lower Leg	3931	Slocum's or similar procedure	No		
Knee and Lower Leg	3935	Synovectomy	No		
Knee and Lower Leg	3940	Synovial biopsy, knee/ lower leg	No	Diagnostic, Day Care	
Knee and Lower Leg	3944	Reconstruction (advancement) posterior tibial tendon with excision of accessory tarsal navicular bone (e.g. Kidner type procedure)	No		

ORTHOPAEDICS

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Knee and Lower Leg	3945	Tendon transplants about knee joint	No		
Knee and Lower Leg	3950	Transplant of tibial tubercle	No		
Knee and Lower Leg	3951	Decompression fasciotomy, leg	No		
Knee and Lower Leg	5890	Ligament reconstruction at the knee joint (I.P.)	No	Independent Procedure	
Knee and Lower Leg	5891	Ligament reconstruction of the knee joint using autogenous graft (I.P.)	No	Independent Procedure	
Muscle	1380	Muscle, repair and suture of	No		
Muscle	1385	Muscle biopsy	No	Diagnostic, Side Room	
Nerves	1390	Nerve biopsy	No	Diagnostic	
Nerves	1395	Nerve repairs (primary) (I.P.)	No	Independent Procedure	
Nerves	1400	Nerve suture (secondary, including grafting and anastomosis)	No		
Nerves	1406	Neuroma, excision of	No	Day Care	
Nerves	1407	Neurectomy	No		
Nerves	5600	Peripheral nerve repairs	No		
Nerves	5605	Peripheral nerve tumour, excision of	No	Day Care	
Other Orthopaedic Procedures	3130	Application of plaster of paris casts as a separate procedure not associated with concurrent surgery (I.P.)	No	Independent Procedure, Day Care	
Other Orthopaedic Procedures	4264	Arthroscopy (joints not otherwise specified) (I.P.)	No	Independent Procedure, Diagnostic	
Other Orthopaedic Procedures	4265	Arthrotomy for removal of loose bodies	No	Day Care	
Other Orthopaedic Procedures	4270	Biopsy of tumour of long bones, open	No	Diagnostic	
Other Orthopaedic Procedures	4272	Excision of large malignant bone tumours for limb conservation	No		
Other Orthopaedic Procedures	4273	Excision of large malignant bone tumours for limb conservation including prosthetic insertion	No		
Other Orthopaedic Procedures	4275	Application of body cast (surgery benefit includes removal)	No	Day Care	
Other Orthopaedic Procedures	4280	Bone cysts (long bones only), excision	No		

ORTHOPAEDICS

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Other Orthopaedic Procedures	4285	Bursectomy, large joints	No	Day Care	
Other Orthopaedic Procedures	4295	Exostosis of long bones, removal	No		
Other Orthopaedic Procedures	4300	Fracture sternum and ribs, operative reduction	No		
Other Orthopaedic Procedures	4301	Limb lengthening (upper or lower limb) including osteotomy procedure and application of fixator devices	No		
Other Orthopaedic Procedures	4310	Partial excision of osteomyelitic bone (e.g. cauterisation, craterisation), bones of foot, ankle (including malleoli), hand or wrist, with or without bone grafting (not for bone biopsy) (I.P.)	No	Independent Procedure	
Other Orthopaedic Procedures	4320	Removal of plates, pins, screws; superficial (includes removal of sternum wire) (I.P.)	No	Independent Procedure, Day Care	
Other Orthopaedic Procedures	4325	Removal of plates, pins, screws; deep dissection through muscle into bone requiring layered repair of incision (I.P.)	No	Independent Procedure, Day Care	
Sacro Iliac Joint	3605	Arthrodesis, sacro iliac joint (I.P.)	No	Independent Procedure	
Sacro Iliac Joint	3610	Aspiration, sacro iliac joint	No	Side Room	
Sacro Iliac Joint	3615	Biopsy of sacro iliac joint region	No	Diagnostic	
Sacro Iliac Joint	3625	Pelvic osteotomy bilateral in ectopia vesica	No		
Tendons	1410	Tendon repairs (primary), single	No		
Tendons	1415	Tendon repairs (primary), multiple	No		
Tendons	1420	Tendon sheath, incision of	No		
Tendons	1425	Tenotomy	No	Day Care	
Tendons	1426	Tenolysis (I.P.)	No	Independent Procedure, Day Care	
Total Joint Replacement	3045	Arthroplasty, using joint prosthesis, single (I.P.)	No	Independent Procedure	
Total Joint Replacement	3050	Arthroplasty, using joint prosthesis, two joints (I.P.)	No	Independent Procedure	
Total Joint Replacement	3055	Arthroplasty, using joint prosthesis, more than two joints (I.P.)	No	Independent Procedure	
Total Joint Replacement	3165	Arthroplasty (I.P.)	No	Independent Procedure	
Total Joint Replacement	3181	Trapezial joint replacement	No		

ORTHOPAEDICS

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Total Joint Replacement	3300	Arthroplasty (forearm & elbow) (I.P.)	No	Independent Procedure	
Total Joint Replacement	3409	Shoulder replacement, total includes reverse total shoulder arthroplasty (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Total Joint Replacement	3655	Arthroplasty of hip using prosthesis, bilateral (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Total Joint Replacement	3660	Arthroplasty of hip using prosthesis, unilateral (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Total Joint Replacement	3661	Revision of total hip arthroplasty, acetabular and femoral components with or without autograft or allograft (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Total Joint Replacement	3909	Prosthetic replacement (total) of knee joints, bilateral (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Total Joint Replacement	3910	Prosthetic replacement (total) of knee joint, unilateral (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Total Joint Replacement	3911	Revision of arthroplasty of knee joint, with or without allograft, one or more components (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Total Joint Replacement	3914	Patellofemoral arthroplasty of knee joint; condyle and plateau medial or lateral compartment (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Total Joint Replacement	3957	Arthroplasty (ankle) (I.P.)	No	Independent Procedure	
Total Joint Replacement	3958	Arthroplasty, ankle with implant (total ankle) (I.P.)	No	Independent Procedure	
Total Joint Replacement	3959	Arthroplasty, ankle revision, total ankle (I.P.)	No	Independent Procedure	
Total Joint Replacement	4181	Metatarsal joint replacement with prosthesis (I.P.)	No	Independent Procedure	
Total Joint Replacement	233409	Revision shoulder replacement, total includes reverse total shoulder arthroplasty	No		Possible co-payment please check Table of Cover
Total Joint Replacement	234706	Shoulder replacement, hemiarthroplasty (humeral head prosthesis) (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Total Joint Replacement	272812	2 stage revision of total hip replacement for infection - first stage	No		Possible co-payment please check Table of Cover
Total Joint Replacement	272813	2 stage revision of total hip replacement for infection - second stage	Yes		Possible co-payment please check Table of Cover
Total Joint Replacement	275817	2-stage revision of total knee replacement for infection - first stage	No		Possible co-payment please check Table of Cover
Total Joint Replacement	275818	2-stage revision of total knee replacement for infection - second stage	Yes		Possible co-payment please check Table of Cover

ORTHOPAEDICS

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Wrist	3159	Arthroscopy of the wrist (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Wrist	3160	Arthrodesis, using bone graft	No		
Wrist	3161	Arthroscopy, wrist, surgical; for infection, lavage and drainage (I.P.)	No	Independent Procedure, Day Care	
Wrist	3162	Arthroscopy, wrist, surgical; synovectomy, partial (I.P.)	No	Independent Procedure, Day Care	
Wrist	3163	Arthroscopy, wrist, surgical; synovectomy, complete (I.P.)	No	Independent Procedure, Day Care	
Wrist	3164	Arthroscopy, wrist, surgical; excision and/ or repair of triangular fibrocartilage and/ or joint debridement (I.P.)	No	Independent Procedure, Day Care	
Wrist	3166	Arthroscopy, wrist, surgical; internal fixation for fracture or instability (I.P.)	No	Independent Procedure	
Wrist	3175	Bone grafting operation on scaphoid	No		
Wrist	3176	Herbert screw fixation, scaphoid	No		
Wrist	3180	Carpal bone (lunate scaphoid trapezium), excision of	No		
Wrist	3185	Carpal tunnel, decompression (I.P.)	No	Independent Procedure, Day Care	
Wrist	3190	Carpus or peri-carpal dislocations, manipulation	No		
Wrist	3191	Endoscopy, wrist, surgical, with release of transverse carpal ligament	No	Day Care	
Wrist	3192	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint	No	Day Care	
Wrist	3195	Corrective osteotomy of lower end of radius	No		
Wrist	3200	Dislocation of wrist, open reduction of	No		
Wrist	3205	Fracture (Colles'), internal fixation of	No		
Wrist	3210	Fracture (Colles'), manipulation and plaster of paris	No	Day Care	
Wrist	3211	Fracture of distal radius, external fixation of	No		
Wrist	3225	Ganglion, surgical removal of	No	Day Care	
Wrist	3229	Intercarpal fusion	No		

ORTHOPAEDICS

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Wrist	3235	Nerve, median and ulnar nerve, repair of	No		
Wrist	3240	Nerve, median or ulnar nerve, repair of	No		
Wrist	3245	Radial styloid, excision of	No		
Wrist	3255	Synovectomy of wrist joint	No	Day Care	
Wrist	3260	Tendon, repair at wrist, single	No		
Wrist	3265	Tendons, repair at wrist, multiple	No		
Wrist	3270	Tendon transfer about the wrist, single	No		
Wrist	3271	Tendon transfer about the wrist, multiple	No		
Wrist	3275	Ulna, lower end of (malunited Colles'), excision of	No		
Wrist	3276	Smith's or Barton's fractures, internal fixation of	No		
Wrist	3277	Manipulation of wrist under general anaesthetic (to gain loss of motion following a surgical procedure or due to scar tissue)	No	Day Care	

PAIN MANAGEMENT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
EEG	5905	Video telemetric electroencephalogram (EEG) recordings including full clinical evaluation and placement of sphenoidal electrodes	No		For procedure codes 5905 and 5906 the benefit incorporates all in-patient attendance
Implantable Pumps	5039	Implantation of catheter system and reservoir; tunnelled, intrathecal or epidural catheter for long term medication administration via an external pump or implantable reservoir/ infusion pump (I.P.)	No	Independent Procedure	Benefit for implantation and maintenance of pain pumps, procedure codes 5038 and 5039, applies for one of the following clinical indications: (a) Diffuse cancer pain (b) Failed back surgery (c) Osteoporosis (d) Arachnoiditis (e) Axial somatic pain (f) Painful neuropathies (g) Spinal cord injury (h) Spasticity arising from multiple sclerosis or cerebral palsy
Implantable Pumps	5042	Removal of subcutaneous implantable pump (does not apply to removal of CVC) (I.P.)	No	Independent Procedure, Side Room	
Nerves	5606	Implantation of neurostimulator electrodes, Vagus nerve	No		
Nerves	5610	Sensory nerve, neurectomy	No		
Nerves	5622	E.C.T. (each session)	No	Day Care	
Neuro Stimulators	5043	Removal of spinal neurostimulator pulse generator or receiver, or neurostimulator electrode percutaneous array(s) or plate/ paddle(s) (I.P.)	No	Independent Procedure, Day Care	

PAIN MANAGEMENT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Neuro Stimulators	5044	Revision including replacement, when performed, or re-positioning of spinal neurostimulator electrode percutaneous array(s) or plate/ paddle(s); includes fluoroscopy (I.P.)	Yes	Independent Procedure, Day Care	
Neuro Stimulators	5051	Replacement of spinal neurostimulator pulse generator or receiver direct or inductive coupling (I.P.)	Yes	Independent Procedure, Day Care	Benefit for the insertion of spinal cord stimulators will be subject to the following criteria being satisfied: (a) Whether or not low or high frequency spinal cord stimulator is used must be specified on the claim form (b) Prior approval is sought by a consultant recognised by Irish Life Health and who also has a Diploma in Pain Medicine (c) The procedure is performed in a hospital that is listed in the Irish Life Health Directory of Hospitals (d) Benefit will be provided for the trial stage and subsequent implantation for members who satisfy the following criteria: (i) An observable pathology concordant with the pain complaint (ii) Further corrective surgical interventions are unlikely to relieve the patient's pain (iii) Non interventional or other conservative therapies have failed (iv) Oral medications are not effective or cause intolerable side effects (v) No untreated chemical dependency exists (vi) Psychological clearance has been obtained through a consultant psychiatrist or clinical psychologist registered with the Psychological Society of Ireland (vii) No contra indications to surgery are present (sepsis, coagulopathy) (viii) Trial screening with the proposed therapy is successful (e) Benefit will be provided for implantation following a successful trial if the procedure is performed for one of the following clinical reasons: (i) Failed back surgery (ii) Complications, including leg pain, from unsuccessful multiple lumbar surgery to repair lower back problems (iii) Reflex sympathetic dystrophy (iv) Arachnoiditis (v) Radiculopathies (vi) Chronic refractory angina (vii) Painful neuropathies (viii) Spinal cord injury (f) Benefit for a day case hospital stay will be provided for the trial stage (g) Benefit for a three day stay for the implantation stage will be provided (h) Benefit will be provided for five days for members who proceed immediately following the trial to implantation during a single hospital admission Note: the relevant documentation to support the precertification application must be submitted to Irish Life Health in advance of treatment Maximum once every 7 years, stimulator or modulator or battery replacement performed within that period will not be payable Only for Irish Life Health approved brands of stimulators

PAIN MANAGEMENT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Neuro Stimulators	5984	Insertion of spinal cord stimulator - trial stage (I.P.)	Yes	Independent Procedure, Day Care	Benefit for the insertion of spinal cord stimulators will be subject to the following criteria being satisfied: (a) Whether or not low or high frequency spinal cord stimulator is used must be specified on the claim form (b) Prior approval is sought by a consultant recognised by Irish Life Health and who also has a Diploma in Pain Medicine (c) The procedure is performed in a hospital that is listed in the Irish Life Health Directory of Hospitals (d) Benefit will be provided for the trial stage and subsequent implantation for members who satisfy the following criteria: (i) An observable pathology concordant with the pain complaint (ii) Further corrective surgical interventions are unlikely to relieve the patient's pain (iii) Non interventional or other conservative therapies have failed (iv) Oral medications are not effective or cause intolerable side effects (v) No untreated chemical dependency exists (vi) Psychological clearance has been obtained through a consultant psychiatrist or clinical psychologist registered with the Psychological Society of Ireland (vii) No contra indications to surgery are present (sepsis, coagulopathy) (viii) Trial screening with the proposed therapy is successful (e) Benefit will be provided for implantation following a successful trial if the procedure is performed for one of the following clinical reasons: (i) Failed back surger (ii) Complications, including leg pain, from unsuccessful multiple lumbar surgery to repair lower back problems (iii) Reflex sympathetic dystrophy (iv) Arachnoiditis (v) Radiculopathies (vi) Chronic refractory angina (vii) Painful neuropathies (viii) Spinal cord injury (f) Benefit for a day case hospital stay will be provided for the trial stage (g) Benefit for a three day stay for the implantation stage will be provided (h) Benefit will be provided for five days for members who proceed immediately following the trial to implantation during a single hospital admission Note: the relevant documentation to support the precertification application must be submitted to Irish Life Health in advance of treatment Maximum once every 7 years, stimulator or modulator or battery replacement performed within that period will not be payable Only for Irish Life Health approved brands of stimulators

PAIN MANAGEMENT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Neuro Stimulators	5999	Insertion of spinal cord stimulator - implantation stage (I.P.)	Yes	Independent Procedure	Benefit for the insertion of spinal cord stimulators will be subject to the following criteria being satisfied: (a) Whether or not low or high frequency spinal cord stimulator is used must be specified on the claim form (b) Prior approval is sought by a consultant recognised by Irish Life Health and who also has a Diploma in Pain Medicine (c) The procedure is performed in a hospital that is listed in the Irish Life Health Directory of Hospitals (d) Benefit will be provided for the trial stage and subsequent implantation for members who satisfy the following criteria: (i) An observable pathology concordant with the pain complaint (ii) Further corrective surgical interventions are unlikely to relieve the patient's pain (iii) Non interventional or other conservative therapies have failed (iv) Oral medications are not effective or cause intolerable side effects (v) No untreated chemical dependency exists (vi) Psychological clearance has been obtained through a consultant psychiatrist or clinical psychologist registered with the Psychological Society of Ireland (vii) No contra indications to surgery are present (sepsis, coagulopathy) (viii) Trial screening with the proposed therapy is successful (e) Benefit will be provided for implantation following a successful trial if the procedure is performed for one of the following clinical reasons: (i) Failed back surgery (ii) Complications, including leg pain, from unsuccessful multiple lumbar surgery to repair lower back problems (iii) Reflex sympathetic dystrophy (iv) Arachnoiditis (v) Radiculopathies (vi) Chronic refractory angina (vii) Painful neuropathies (viii) Spinal cord injury (f) Benefit for a day case hospital stay will be provided for the trial stage (g) Benefit for a three day stay for the implantation stage will be provided (h) Benefit will be provided for five days for members who proceed immediately following the trial to implantation during a single hospital admission Note: the relevant documentation to support the precertification application must be submitted to Irish Life Health in advance of treatment Maximum once every 7 years, stimulator or modulator or battery replacement performed within that period will not be payable Only for Irish Life Health approved brands of stimulators
Neuro Stimulators	636052	Removal of implanted neurostimulator	No		

PAIN MANAGEMENT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Neuro Stimulators	636999	Combined fee for insertion of spinal cord stimulator - trial and implantation stage on same day (I.P.)	Yes	Independent Procedure	Benefit for the insertion of spinal cord stimulators will be subject to the following criteria being satisfied: (a) Whether or not low or high frequency spinal cord stimulator is used must be specified on the claim form (b) Prior approval is sought by a consultant recognised by Irish Life Health and who also has a Diploma in Pain Medicine (c) The procedure is performed in a hospital that is listed in the Irish Life Health Directory of Hospitals (d) Benefit will be provided for the trial stage and subsequent implantation for members who satisfy the following criteria: (i) An observable pathology concordant with the pain complaint (ii) Further corrective surgical interventions are unlikely to relieve the patient's pain (iii) Non interventional or other conservative therapies have failed (iv) Oral medications are not effective or cause intolerable side effects (v) No untreated chemical dependency exists (vi) Psychological clearance has been obtained through a consultant psychiatrist or clinical psychologist registered with the Psychological Society of Ireland (vii) No contra indications to surgery are present (sepsis, coagulopathy) (viii) Trial screening with the proposed therapy is successful (e) Benefit will be provided for implantation following a successful trial if the procedure is performed for one of the following clinical reasons: (i) Failed back surgery (ii) Complications, including leg pain, from unsuccessful multiple lumbar surgery to repair lower back problems (iii) Reflex sympathetic dystrophy (iv) Arachnoiditis (v) Radiculopathies (vi) Chronic refractory angina (vii) Painful neuropathies (viii) Spinal cord injury (f) Benefit for a day case hospital stay will be provided for the trial stage (g) Benefit for a three day stay for the implantation stage will be provided (h) Benefit will be provided for five days for members who proceed immediately following the trial to implantation during a single hospital admission Note: the relevant documentation to support the precertification application must be submitted to Irish Life Health in advance of treatment Maximum once every 7 years, stimulator or modulator or battery replacement performed within that period will not be payable Only for Irish Life Health approved brands of stimulators
Pain Block	5719	Chemical sympathectomy, lumbar or coeliac plexus under image guidance (I.P.)	No	Independent Procedure, Side Room	
Pain Injection	5575	Injection of trigeminal ganglion via foramen ovale under image guidance (I.P.)	No	Independent Procedure, Side Room	
Pain Injection	5580	Destruction by radiofrequency lesioning of trigeminal ganglion via foramen ovale under x-ray guidance via foramen ovale (I.P.)	No	Independent Procedure, Day Care	
Pain Injection	5611	Transforaminal injection of anaesthetic agent, assessment of response and application of steroid if indicated to medial branch nerve or dorsal root ganglion at one or more levels under image guidance (I.P.)	No	Independent Procedure, Side Room, Local Anaesthetic	
Pulsed Radiofrequency	5612	Pulsed radiofrequency (PRF) lesioning of medial branch nerve or dorsal root ganglion, one or more levels under image guidance with sensorimotor testing (I.P.)	No	Independent Procedure, Day Care, Local Anaesthetic	
Rhizotomy	5616	Initial/ first neurodestructive thermal rhizotomy (temperature > 69°C), under image guidance, with sensory and motor testing, one or more levels, lumbar, sacral or thoracic (I.P.)	No	Independent Procedure, Day Care, Local Anaesthetic	Benefit is only payable as an initial procedure The following information must be provided on the claim form before benefit can be considered for payment: (a) Details of the level(s) that were treated by rhizotomy i.e. L4/5 or L5/S1 and whether this was carried out on the left or right side of the spine (b) Confirm the temperature used to perform the procedure

PAIN MANAGEMENT

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Rhizotomy	5617	Initial/ first neurodestructive thermal rhizotomy (temperature > 69°C), under image guidance, with sensory and motor testing, one or more levels, cervical (I.P.)	No	Independent Procedure, Day Care, Local Anaesthetic	Benefit is only payable as an initial procedure The following information must be provided on the claim form before benefit can be considered for payment: (a) Details of the level(s) that were treated by rhizotomy i.e. L4/5 or L5/S1 and whether this was carried out on the left or right side of the spine (b) Confirm the temperature used to perform the procedure
Rhizotomy	5618	Repeat of procedure 5616 to the same anatomical site, one or more levels, lumbar, sacral or thoracic - less than 18 months after initial procedure (I.P.)	No	Independent Procedure, Day Care	The following information must be provided on the claim form before benefit can be considered for payment: (a) Date of initial treatment (a) Details of the level(s) that were treated by rhizotomy i.e. L4/5 or L5/S1 and whether this was carried out on the left or right side of the spine (b) Confirm the temperature used to perform the procedure
Rhizotomy	5619	Repeat of procedure 5617 to the same anatomical site, one or more levels, cervical - less than 18 months after initial procedure (I.P.)	No	Independent Procedure, Day Care, Local Anaesthetic	The following information must be provided on the claim form before benefit can be considered for payment: (a) Date of initial treatment (b) Details of the level(s) that were treated by rhizotomy i.e. C4/5 and whether this was carried out on the left or right side of the spine (c) Confirm the temperature used to perform the procedure
Rhizotomy	225918	Repeat of procedure 5616 to the same anatomical site, one or more levels, lumbar, sacral or thoracic - 18 months or more after previous procedure (I.P.)	No	Independent Procedure, Day Care	The following information must be provided on the claim form before benefit can be considered for payment: (a) Date of initial treatment (a) Details of the level(s) that were treated by rhizotomy i.e. L4/5 or L5/S1 and whether this was carried out on the left or right side of the spine (b) Confirm the temperature used to perform the procedure
Rhizotomy	225919	Repeat of procedure 5617 to the same anatomical site, one or more levels, cervical - 18 months or more after previous procedure (I.P.)	No	Independent Procedure, Day Care, Local Anaesthetic	The following information must be provided on the claim form before benefit can be considered for payment: (a) Date of initial treatment (b) Details of the level(s) that were treated by rhizotomy i.e. C4/5 and whether this was carried out on the left or right side of the spine (c) Confirm the temperature used to perform the procedure

RADIOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Anaesthesia	192201	General anaesthesia for diagnostic scans, for child under the age of 2	Yes		
Anaesthesia	192203	General anaesthesia for diagnostic scans, for adults	Yes		
CT	6102	Brain, without contrast material	No		Codes 6104, 6106, 6107 and 6108 are not payable with 6102 or 6103, if done at the same time
CT	6103	Brain, with contrast material	No		Codes 6104, 6106, 6107 and 6108 are not payable with 6102 or 6103, if done at the same time
CT	6104	Orbit, sella or outer, middle, or inner ear; without contrast material	No		Codes 6104, 6106, 6107 and 6108 are not payable with 6102 or 6103, if done at the same time
CT	6106	Orbit, sella or outer, middle, or inner ear; with contrast material	No		Codes 6104, 6106, 6107 and 6108 are not payable with 6102 or 6103, if done at the same time
CT	6107	Maxillofacial area, without contrast material	No		Codes 6104, 6106, 6107 and 6108 are not payable with 6102 or 6103, if done at the same time
CT	6108	Maxillofacial area, with contrast material	No		Codes 6104, 6106, 6107 and 6108 are not payable with 6102 or 6103, if done at the same time
CT	6109	Thorax, without contrast material	No		
CT	6111	CT scanning for biopsy or drainage	No	Side Room, Monitored Anaesthesia Care	
CT	6112	Thorax, with contrast material	No		
CT	6113	High resolution, lungs, without contrast	No		

RADIOLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
CT	6114	Abdomen (including pelvis), without contrast	No		Code 6114 is not payable with 6116, if done at the same time
CT	6116	Abdomen (including pelvis), with contrast	No		Code 6114 is not payable with 6116, if done at the same time
CT	6123	CT Colonography	No	Side Room	
CT	6124	Ablation therapy for reduction or eradication of one or more pulmonary tumour(s) under CT guidance, including pleura or chest wall when involved by tumour extension, percutaneous, radiofrequency (benefit for CT guidance included) (I.P.)	No	Independent Procedure	
CT	6224	Spine	No		
CT	6226	Long bones	No		
CT	6227	Joints	No		
CT	6228	Spine	No		
CT	6229	Feet/ hands	No		
Fluoroscopic Guidance	770402	Conversion of a gastrostomy feeding tube to a gastrojejunostomy feeding tube under fluoroscopic guidance (not claimable with procedure code 7036)	No		1 Night Only
Interventional Radiology	1196	Stereotactic localisation core needle biopsy of breast (I.P.)	No	Independent Procedure, Diagnostic, Side Room	
Interventional Radiology	6676	Placement of fiducial markers for radiation therapy guidance of prostate (via needle, any approach), single or multiple includes ultrasound guidance	No	Side Room, Monitored Anaesthesia Care	
Interventional Radiology	6686	Biopsy of focal lesion in the liver, kidney, pancreas or spleen including embolisation (e.g. Gelfoam), if performed	No	Side Room, Monitored Anaesthesia Care	
Interventional Radiology	6687	Biopsy of focal lesion, under CT guidance, in the liver, kidney, pancreas or spleen including embolisation (e.g. gelfoam), if performed	No	Side Room, Monitored Anaesthesia Care	
Interventional Radiology	6688	Radiofrequency ablation of liver tumour(s) including embolisation (e.g. gelfoam), if performed	No	Side Room	
Interventional Radiology	6691	Radiofrequency ablation of renal tumour(s) including embolisation (e.g. gelfoam), if performed	No	Side Room	
Interventional Radiology	6692	Biopsy of lymph nodes, deep, under CT guidance	No	Side Room, Monitored Anaesthesia Care	
Interventional Radiology	6721	Spinal arteriogram	No	Side Room	

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Interventional Radiology	6741	Transcatheter permanent occlusion or embolisation, percutaneous, any method non-central nervous system, head or neck (extracranial, brachiocephalic branch)	No	Side Room	Includes angiographic evaluation before, during and immediately after the procedure, at the same session, following a full assessment of the patient in a multidisciplinary team, which involves one or more consultants in the following specialities: Dermatology, Plastic Surgery, Haematology and Interventional Radiology
Interventional Radiology	6742	Transcatheter permanent occlusion or embolisation (e.g. for tumour destruction, to achieve haemostasis, to occlude a vascular malformation), percutaneous, any method non-central nervous system, non head or neck (extracranial, brachiocephalic branch) following a full assessment involving a consultant in one or more disciplines of Plastic Surgery, Dermatology, Haematology and Interventional Radiology	No	Side Room	Includes angiographic evaluation before, during and immediately after the procedure, at the same session, following a full assessment of the patient in a multidisciplinary team, which involves one or more consultants in the following specialities: Dermatology, Plastic Surgery, Haematology and Interventional Radiology
Interventional Radiology	6743	Image-guided percutaneous core needle biopsy, including consultant Radiologist interpretation and report (ultrasound or stereotactic localisation) (I.P.)	No	Independent Procedure, Side Room, Monitored Anaesthesia Care	
Interventional Radiology	66684	Uterine artery embolisation for fibroids including angiography and fluoroscopy (I.P.)	No	Independent Procedure	Conditions of payment for code 66684: (a) The Radiologist who performs the procedure must have specialised embolisation experience or undergone appropriate training and be registered with Irish Life Health Healthcare (b) All cases of uterine artery embolisation must be performed in a hospital listed in the Irish Life Health Directory of hospitals, by a consultant radiologist (c) Benefit will not be made in the following circumstances: (i) Where there is any evidence of current or recent infection in the genital tract (ii) When a patient is unwilling to consent to hysterectomy if the embolisation procedure is complicated (iii) If the above criteria are not satisfied in full
Interventional Radiology	66744	Completed radiological examination and evaluation including imaging (mammography and/ or ultrasound), and immediate image-guided percutaneous core needle biopsy; where performed on same day by a consultant Radiologist (I.P.)	No	Independent Procedure, Side Room, Diagnostic	
Interventional Radiology	770074	Fiducial marker placement liver - other visceral organ	No	Side Room, Monitored Anaesthesia Care	
Interventional Radiology	770501	Microwave ablation of liver lesion(s)	No		
Interventional Radiology	770717	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including image guidance under general anaesthetic	No	Day Care	
MRA	62300181	MRA for exclusion or further investigation of stroke	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62300201	MRA for exclusion or further investigation of intracranial aneurysm	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62300211	MRA for exclusion or further investigation of intracranial arteriovenous malformation	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62300221	MRA for exclusion or further investigation of venous sinus thrombosis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62301761	MRA: vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62301771	MRA: obstruction of the superior vena cava, inferior vena cava or a major pelvic vein	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRA	62301791	MRA: renal artery stenosis post renal transplant	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62301801	MRA: renal artery stenosis in patients with refractory hypertension requiring multiple therapies, or in patients with documented renal insufficiency in whom renal vascular disease is being considered and in whom angioplasty and stenting is being considered	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62307211	MRA: peripheral arteries to determine the presence and extent of peripheral arterial disease in lower extremities	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62310201	MRA for exclusion or further investigation of intracranial aneurysm	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62310211	MRA for exclusion or further investigation of intracranial arteriovenous malformation	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62310221	MRA for exclusion or further investigation of venous sinus thrombosis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62311761	MRA: vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62311771	MRA: obstruction of the superior vena cava, inferior vena cava or a major pelvic vein	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62311791	MRA: renal artery stenosis post renal transplant	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62311801	MRA: renal artery stenosis in patients with refractory hypertension requiring multiple therapies, or in patients with documented renal insufficiency in whom renal vascular disease is being considered and in whom angioplasty and stenting is being considered	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRA	62317211	MRA: peripheral arteries to determine the presence and extent of peripheral arterial disease in lower extremities	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	6233	Cardiac magnetic resonance imaging (MRI) with or without contrast enhancement	No		GP Referrals not accepted, only referral from Consultants will be considered Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	6234	Paediatric cardiac magnetic resonance imaging, for congenital cardiac anomalies in infants and children under 16 years of age, including detailed segmental analysis, functional assessment of ventricular function, phase contrast quantification of great vessel AV valve outflow tract flow, ventricular volumes, angiography, three dimensional image reconstruction, tissue tagging and delayed gadolinium enhancement of myocardium, including imaging acquisition, post-processing of volume and flow data report of MRI MRA.	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	6746	Breast biopsy with the use of MRI to guide localisation of breast lesion(s) which cannot be visualised with mammography or ultrasonography (I.P.)	No	Independent Procedure, Side Room, Monitored Anaesthesia Care	Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300001	Tumour of the brain or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62300011	Skull base or orbital tumour	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300021	Acoustic neuroma	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300031	Pituitary tumour - in the case of females with elevated prolactin levels, MRI benefit is only allowable following repeated testing and exclusion of the presence of macro prolactin and there continues to be significant hyperprolactinaemia	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300041	Inflammation of the brain or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300051	Encephalopathy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300061	Encephalitis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300071	Suspect leukodystrophies	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300081	ENT problems – following consultation with a radiologist	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300091	Demyelinating disease of the brain	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300101	Congenital malformation of brain or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300111	Venous sinus thrombosis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300121	Screening of intracranial aneurysm in the following high risk individuals - positive family history, defined as 2 or more first degree relatives with subarachnoid haemorrhages	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300131	Screening of intracranial aneurysm in the following high risk individuals - patients with polycystic kidney disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300141	Epilepsy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300151	Stroke	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300161	Post-operative follow-up after brain surgery	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300191	Vertebral dissection	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300301	MRI: suspected intra-orbital or visual pathway lesions	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300311	MRI: dysthyroid eye disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62300321	MRI: diplopia	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300401	Tumour of the CNS or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300411	Inflammation of the CNS or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300421	Demyelinating disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300431	Spinal cord compression (acute)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300441	Congenital malformations of the spinal cord, cauda equina or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300451	Syrinx – congenital or acquired	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300461	Myelopathy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300471	Absent or reduced sensation on clinical examination	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300481	Absent or reduced reflexes	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300491	Muscle wasting	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300501	Severe intractable arm pain where symptoms have been present for more than 6 weeks	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300511	Cervical/ thoracic or lumbar radicular pain persisting for greater than 6 weeks when decompression surgery is being considered following referral by a consultant	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300521	Axial neck pain/ thoracic back pain/ axial lumbar spine pain, persisting for greater then 3 months following referral by a consultant	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300531	Reduced power on physical examination	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300541	Previous spinal surgery	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300551	Trauma	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300561	Spinal disease in pregnancy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300571	Tumour of the CNS or meninges (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62300581	Inflammation of the CNS or meninges (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300591	Demyelinating disease (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300601	Acute spinal cord compression (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300611	Congenital malformations of the spinal cord, cauda equina or meninges (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300621	Syrinx – congenital or acquired (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300631	Myelopathy (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300641	Absent or reduced sensation on clinical examination (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300651	Absent or reduced reflexes (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300661	Muscle wasting (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300671	Severe intractable arm pain where symptoms have been present for more than 6 weeks (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300681	Radicular pain persisting for greater than 6 weeks when decompression surgery is being considered following referral by a consultant (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300691	Axial spine pain, persisting for greater then 3 months following referral by a consultant (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300701	Reduced power on physical examination (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300751	Previous spinal surgery (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300761	Trauma (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62300901	Spinal disease in pregnancy (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301001	MRI: tumour arising in bone or other connective tissue	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301011	MRI: infection arising in bone or other connective tissue	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301021	MRI: osteonecrosis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62301031	MRI: sacro-iliac joints in the following circumstances: (a) suspicion of the presence of ankylosing spondylitis and (b) patients have negative or inconclusive plan radiography films of the sacro-iliac joints and (c) patients are HLA B27 positive	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301101	MRI: slipped upper femoral epiphysis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301111	MRI: post inflammatory or post traumatic epiphyseal fusion in a person under 16 years of age	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301121	MRI: complex cases of juvenile dermatomyositis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301131	MRI: Gaucher's disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301151	MRI: juvenile dermatomyositis by guiding biopsy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301161	MRI: for exclusion, further investigation and monitoring of derangement of one or both hips and supporting structures	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301171	MRI: for exclusion, further investigation and monitoring of derangement of one knee and supporting structures	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301181	MRI: for exclusion, further investigation and monitoring of derangement of both knees and supporting structures	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301201	MRI cardiovascular system: congenital heart disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301211	MRI cardiovascular system: tumour of the heart or a great vessel	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301221	MRI cardiovascular system: aortic dissection/ aneurysm	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301231	MRI cardiovascular system: abnormality of thoracic aorta	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301241	MRI cardiovascular system: post operative aortic graft infection or dehiscence	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301251	MRI cardiovascular system: for further investigation, in persons under the age of 16 years, of the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301311	MRI abdomen: characterisation of equivocal liver lesions identified in ultrasound or CT	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301321	MRI abdomen: assessment of liver lesions in patients with known malignant disease for potential liver resection	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301331	MRI abdomen: staging of abdominal masses where CT is inconclusive	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301341	Pre procedure planning for uterine artery embolisation of uterine fibroids - adenomyosis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62301351	MRI abdomen: staging of gynaecologic malignancies (endometrial, cervical and ovarian)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301361	MRI abdomen: staging of rectal cancer	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301371	MRI abdomen: post operative recurrence of rectal cancer following CT and if tissue remains	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301381	MRI abdomen: staging of bladder cancer	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301391	MRI abdomen: detection of small pancreatic tumours not visible by CT, only if negative high resolution triphasic CT scan of pancreas	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301401	MRI abdomen: assessment of fistulae/ abscesses/ strictures in patients with established Crohn's disease following discussion with a multi-disciplinary team	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301501	Perineal abscess	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301511	Perineal fistula	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301531	Assessment of the inferior vena cava in patients with known solid renal tumour	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301561	MR urography in pregnancy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62301601	Magnetic Resonance Cholangiopancreatography (MRCP): pancreatic and biliary disease where conventional methodology has failed and ERCP is considered undesirable	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62302501	Malignant soft tissue tumours for diagnosis and staging	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62302521	Congenital uterine or anorectal abnormality	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62302601	Bone metastases due to primary cancer	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62302611	Investigation of polymyalgia, if pathology suggests diagnosis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62302621	Investigation of infiltrating marrow disorders	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307001	Breast cancer - where mammogram and/ or ultrasound are negative for pathology but there continues to be a high index of clinical suspicion (e.g. in persons with inherited BRCA1 and BRCA2 mutations)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307011	MRI: one ankle - benefit payable for scanning of derangement of ankle and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62307021	MRI: both ankles - benefit payable for scanning of derangement of ankles and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307031	MRI: one foot (excludes hind foot)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307041	MRI: both feet (excludes hind feet)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307051	MRI: suspected tarsal coalition	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307061	MRI: soft tissue tumours in the feet	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307071	MRI: posterior tibial nerve compression in the presence of persistent symptoms and signs and failure to respond to at least 6 weeks of appropriate therapy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307081	MRI: one shoulder and supporting structures; benefit payable for scanning of derangement of shoulder and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307091	MRI: both shoulders and supporting structures; benefit payable for scanning of derangement of shoulders and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307101	MRI: one elbow and supporting structures; benefit payable for scanning of derangement of elbow and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307111	MRI: both elbows and supporting structures; benefit payable for scanning of derangement of elbows and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307121	MRI: one wrist and supporting structures; benefit payable for scanning of derangement of wrist and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307131	MRI: both wrists and supporting structures; benefit payable for scanning of derangement of wrists and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307141	MRI abdomen: post surgical MRI following uterine artery embolisation for fibroids	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307151	MRI abdomen: further investigation of adrenal masses identified on CT scanning	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307161	MRI abdomen: further investigation of complex/ indeterminable/ solid renal parenchymal masses	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307171	MRI abdomen: placenta accreta/ percreta	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307191	MR enterography/ enteroclysis: to assess disease activity in patients with Crohn's disease of the small bowel	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307201	MR enterography/ enteroclysis: to exclude Crohn's disease in patients with chronic abdominal pain, diarrhoea and weight loss when the referral for MRI is made by a consultant Gastroenterologist or surgeon with an interest in gastrointestinal disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307221	Breast: for pre-operative evaluation of patients with invasive lobular carcinoma	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62307231	Breast: for pre-operative evaluation of patients with multi-focal or multi-centric disease and age less than 40 years	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307241	Breast: to rule out intra-capsular implant rupture following assessment by a breast or plastic surgeon, where breast ultrasound is equivocal or non-diagnostic	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62307251	Staging of prostate cancer	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310001	Tumour of the brain or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310011	Skull base or orbital tumour	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310021	Acoustic neuroma	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310031	Pituitary tumour - in the case of females with elevated prolactin levels, MRI benefit is only allowable following repeated testing and exclusion of the presence of macro prolactin and there continues to be significant hyperprolactinaemia	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310041	Inflammation of the brain or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310051	Encephalopathy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310061	Encephalitis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310071	Suspect leukodystrophies	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310081	ENT problems – following consultation with a radiologist	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310091	Demyelinating disease of the brain	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310101	Congenital malformation of brain or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310111	Venous sinus thrombosis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310121	Screening of intracranial aneurysm in the following high risk individuals - positive family history, defined as 2 or more first degree relatives with subarachnoid haemorrhages	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310131	Screening of intracranial aneurysm in the following high risk individuals - patients with polycystic kidney disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310141	Epilepsy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310151	Stroke	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62310161	Post-operative follow-up after brain surgery	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310191	Vertebral dissection	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310301	MRI: suspected intra-orbital or visual pathway lesions	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310311	MRI: dysthyroid eye disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310321	MRI: diplopia	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310401	Tumour of the CNS or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310411	Inflammation of the CNS or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310421	Demyelinating disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310431	Spinal cord compression (acute)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310441	Congenital malformations of the spinal cord, cauda equina or meninges	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310451	Syrinx – congenital or acquired	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310461	Myelopathy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310471	Absent or reduced sensation on clinical examination	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310481	Absent or reduced reflexes	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310491	Muscle wasting	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310501	Severe intractable arm pain where symptoms have been present for more than 6 weeks	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310511	Cervical/ thoracic or lumbar radicular pain persisting for greater than 6 weeks when decompression surgery is being considered following referral by a consultant	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310521	Axial neck pain/ thoracic back pain/ axial lumbar spine pain, persisting for greater then 3 months following referral by a consultant	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310531	Reduced power on physical examination	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62310541	Previous spinal surgery	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310551	Trauma	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310561	Spinal disease in pregnancy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310571	Tumour of the CNS or meninges (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310581	Inflammation of the CNS or meninges (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310591	Demyelinating disease (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310601	Acute spinal cord compression (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310611	Congenital malformations of the spinal cord, cauda equina or meninges (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310621	Syrinx – congenital or acquired (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310631	Myelopathy (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310641	Absent or reduced sensation on clinical examination (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310651	Absent or reduced reflexes (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310661	Muscle wasting (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310671	Severe intractable arm pain where symptoms have been present for more than 6 weeks (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310681	Radicular pain persisting for greater than 6 weeks when decompression surgery is being considered following referral by a consultant (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310691	Axial spine pain, persisting for greater then 3 months following referral by a consultant (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310701	Reduced power on physical examination (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310751	Previous spinal surgery (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62310761	Trauma (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62310901	Spinal disease in pregnancy (whole spine)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311001	MRI: tumour arising in bone or other connective tissue	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311011	MRI: infection arising in bone or other connective tissue	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311021	MRI: osteonecrosis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311031	MRI: sacro-iliac joints in the following circumstances; (a) suspicion of the presence of ankylosing spondylitis and (b) patients have negative or inconclusive plan radiography films of the sacro-iliac joints and (c) patients are HLA B27 positive	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311101	MRI: slipped upper femoral epiphysis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311111	MRI: post inflammatory or post traumatic epiphyseal fusion in a person under 16 years of age	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311121	MRI: complex cases of juvenile dermatomyositis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311131	MRI: Gaucher's disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311151	MRI: juvenile dermatomyositis by guiding biopsy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311161	MRI: for exclusion, further investigation and monitoring of derangement of one or both hips and supporting structures	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311171	MRI: for exclusion, further investigation and monitoring of derangement of one knee and supporting structures	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311181	MRI: for exclusion, further investigation and monitoring of derangement of both knees and supporting structures	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311201	MRI cardiovascular system: congenital heart disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311211	MRI cardiovascular system: tumour of the heart or a great vessel	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311221	MRI cardiovascular system: aortic dissection/ aneurysm	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311231	MRI cardiovascular system: abnormality of thoracic aorta	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311241	MRI cardiovascular system: post operative aortic graft infection or dehiscence	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311251	MRI cardiovascular system: for further investigation, in persons under the age of 16 years, of the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62311311	MRI abdomen: characterisation of equivocal liver lesions identified in ultrasound or CT	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311321	MRI abdomen: assessment of liver lesions in patients with known malignant disease for potential liver resection	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311331	MRI abdomen: staging of abdominal masses where CT is inconclusive	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311341	Pre-procedure planning for uterine artery embolisation of uterine fibroids - adenomyosis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311351	MRI abdomen: staging of gynaecologic malignancies (endometrial, cervical and ovarian)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311361	MRI abdomen: staging of rectal cancer	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311371	MRI abdomen: post operative recurrence of rectal cancer following CT and if tissue remains	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311381	MRI abdomen: staging of bladder cancer	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311391	MRI abdomen: detection of small pancreatic tumours not visible by CT, only if negative high resolution triphasic CT scan of pancreas	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311401	MRI abdomen: assessment of fistulae/ abscesses/ strictures in patients with established Crohn's disease following discussion with a multi-disciplinary team	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311501	Perineal abscess	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311511	Perineal fistula	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311531	Assessment of the inferior vena cava in patients with known solid renal tumour	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62311601	Magnetic Resonance Cholangiopancreatography (MRCP): pancreatic and biliary disease where conventional methodology has failed and ERCP is considered undesirable	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62312501	Malignant soft tissue tumours for diagnosis and staging	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62312521	Congenital uterine or anorectal abnormality	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62312601	Bone metastases due to primary cancer	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62312611	Investigation of polymyalgia, if pathology suggests diagnosis	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62312621	Investigation of infiltrating marrow disorders	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62317001	MRI: one ankle - benefit payable for scanning of derangement of ankle and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317031	MRI: one foot (excludes hind foot)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317041	MRI: both feet (excludes hind feet)	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317051	MRI: suspected tarsal coalition	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317061	MRI: soft tissue tumours in the feet	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317071	MRI: posterior tibial nerve compression in the presence of persistent symptoms and signs and failure to respond to at least 6 weeks of appropriate therapy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317081	MRI: one shoulder and supporting structures; benefit payable for scanning of derangement of shoulder and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317091	MRI: both shoulders and supporting structures; benefit payable for scanning of derangement of shoulders and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317101	MRI: one elbow and supporting structures; benefit payable for scanning of derangement of elbow and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317111	MRI: both elbows and supporting structures; benefit payable for scanning of derangement of elbows and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317121	MRI: one wrist and supporting structures; benefit payable for scanning of derangement of wrist and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317131	MRI: both wrists and supporting structures; benefit payable for scanning of derangement of wrists and supporting structures only	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317141	MRI abdomen: post surgical MRI following uterine artery embolisation for fibroids	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317151	MRI abdomen: further investigation of adrenal masses identified on CT scanning	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317161	MRI abdomen: further investigation of complex/ indeterminable/ solid renal parenchymal masses	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317171	MRI abdomen: placenta accreta/ percreta	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317172	MRI during pregnancy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317173	MRI for paediatric investigations	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317181	MR enterography/ enteroclysis: exclusion of Crohn's disease in patients less than 18 years following review by a paediatrician	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

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SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
MRI	62317191	MR enterography/ enteroclysis: to assess disease activity in patients with Crohn's disease of the small bowel	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317201	MR enterography/ enteroclysis: to exclude Crohn's disease in patients with chronic abdominal pain, diarrhoea and weight loss when the referral for MRI is made by a consultant Gastroenterologist or surgeon with an interest in gastrointestinal disease	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317221	Breast: for pre-operative evaluation of patients with invasive lobular carcinoma	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317231	Breast: for pre-operative evaluation of patients with multi-focal or multi-centric disease and age less than 40 years	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317241	Breast: to rule out intra-capsular implant rupture following assessment by a breast or plastic surgeon, where breast ultrasound is equivocal or non-diagnostic	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317251	Staging of prostate cancer	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRI	62317252	MRI of prostate for cancer detection	No		
MRI	62317290	MRI dynamic pelvic floor for assessment of incontinence or abstractive defaecation	No		
MRI	62317291	MRI dynamic (cine) with rectal contrast	No		
MRI	62317292	MRI guidance for prostate biopsy	No		
MRI	62317293	MRI dynamic cone with rectal contrast	No		
MRU	62301551	MR urography (MRU) in patients with urographic contrast allergy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRU	62311551	MR urography (MRU) in patients with urographic contrast allergy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
MRU	62311561	MR urography in pregnancy	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies
Paediatric	6223	CT scanogram of lower limbs (paediatric)	No		
Paediatric	62307181	MR enterography/ enteroclysis: exclusion of Crohn's disease in patients less than 18 years following review by a paediatrician	No		Anaesthetist rate only applicable when a full general anaesthetic is administered. For all other anaesthesia, code 399 for monitored anaesthesia applies

RADIOTHERAPY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Anaesthesia	5966	General anaesthetic for mould making in preparation for radiotherapy, in children under 16 years of age	No		
Anaesthesia	5967	General anaesthetic for simulator mapping for radiotherapy in children under 16 years of age, one or more sessions	No		
Anaesthesia	5968	General anaesthetic for radiotherapy treatment in children under 16 years of age, per session	No		

RADIOTHERAPY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Brachytherapy - HDR	5659	Brachytherapy - High dose radiation, intracavity cylinder insertion non operative; insertion of a single applicator without the need for operative placement, all inclusive benefit for applicator placement and plan generated for each treatment. All inclusive benefit for multiple treatment fractions. The benefit includes one follow-up outpatient consultation	No		
Brachytherapy - HDR	5661	Brachytherapy - High dose radiation, intracavity gynaecological device inserted in theatre. Insertion of more than one applicator (such as tandems and/or ovoids or ring for cervix, vagina, or uterine cavity brachytherapy). Generation of complex computerised plan with normal tissue dose determination, sagittal, coronal and transverse slices generated. All inclusive benefit for multiple treatment fractions. The benefit includes one follow-up outpatient consultation after the course of treatment	No		
Brachytherapy - HDR	5682	High dose radiation brachytherapy (HDR) gynaecological (no surgery case). Benefit includes placement of treatment applicators, computerised planning, dosimetry and brachytherapy treatment sessions	No		The consultant benefit for this code is claimable for each subsequent session during the patient's stay
Brachytherapy - HDR	5683	High dose radiation brachytherapy (HDR) post hysterectomy. Benefit includes insertion of treatment applicators, computerised planning, dosimetry and brachytherapy treatment session	No	Day Care	The consultant benefit for this code is claimable for each subsequent session during the patient's stay
Brachytherapy - HDR	5684	High dose radiation brachytherapy (HDR) to prostate, benefit includes computerised planning, dosimetry, placement of treatment applicators for temporary implants and treatment sessions. The benefit includes one follow-up outpatient consultation after the course of treatment	No		
Brachytherapy - HDR	5686	High dose radiation brachytherapy (HDR) primary treatment for intact breast, benefit includes computerised planning, dosimetry, placement of treatment applicators and treatment sessions. The benefit includes one follow-up outpatient consultation after the course of treatment	No		
Brachytherapy - HDR	5689	High dose radiation brachytherapy interstitial (e.g. head and neck), benefit includes computerised planning, dosimetry, placement of treatment applicators and treatment sessions. The benefit includes one follow-up outpatient consultation after the course of treatment	No		
Brachytherapy - Interstitial	1199	Placement of radiotherapy markers after loading catheter(s) into the breast for interstitial radioelement (brachytherapy) application at the same time or subsequent to breast surgery, includes imaging guidance	No		50% benefit applies if carried out at the same session as breast surgery
Brachytherapy - Interstitial	5662	Intraluminal - endobronchial, oesophagus or bile duct	No		Insertion of applicator in theatre
Brachytherapy - Interstitial	5663	Interstitial needles insertion for breast	No		Insertion of needles into tumour(s) necessitating a surgical procedure in theatre under anaesthetic
Brachytherapy - Interstitial	5664	Interstitial needles insertion for head & neck	No		Insertion of needles into tumour(s) necessitating a surgical procedure in theatre under anaesthetic
Brachytherapy - Interstitial	5666	Interstitial needles insertion for gynaecological	No		Insertion of needles into tumour(s) necessitating a surgical procedure in theatre under anaesthetic
Brachytherapy - Interstitial	5667	Interstitial needles insertion for ano-rectal	No		Insertion of needles into tumour(s) necessitating a surgical procedure in theatre under anaesthetic
Brachytherapy - Interstitial	5668	Interstitial needles insertion for sarcoma	No		Insertion of needles into tumour(s) necessitating a surgical procedure in theatre under anaesthetic
Brachytherapy - LDR	5676	Intraoperative implantation of non cylinder intracavity device (to be read in conjunction with code 5677)	No		
Brachytherapy - LDR	5677	Brachytherapy planning review and treatment delivery (LDR), multiple treatment fractions	No		
Brachytherapy - LDR	5678	Interstitial iridium needles insertion (LDR), including tube placement in theatre under anaesthetic, manual placement of each needle, dose calculations and material preparation	No		

RADIOTHERAPY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Brachytherapy - RASI	5726	Detailed prostate volume study under ultrasound guidance with immediate transperineal placement of needles/ catheters into prostate with multiple interstitial radio element seed application with real time planning allowing dose/ seed adjustment as necessary, with or without cystoscopy - Radiotherapist benefit	No		
Brachytherapy - RASI	5995	Transrectal ultrasound for detailed prostate tumour and prostate volume estimation includes modelling and planning for 3-D template guidance for stage two procedure - Radiotherapist benefit	No		
Brachytherapy - RASI	5996	Transrectal and fluoroscopic guidance during second stage procedure of placement of radioactive seeds in prostate includes accurate calibration for template guidance; benefit includes follow-up CT pelvic examination - Radiotherapist benefit	No		
Brachytherapy - RASI	5997	Detailed prostate volume study under anaesthesia includes tumour and prostate volume estimation; modelling and planning, patient consultation, with or without digital rectal examination - Radiotherapist benefit (I.P.)	No	Independent Procedure	
Site Specific	776800	Ocular brachytherapy - implantation of radioactive scleral plaque	No		
Site Specific	776801	Ocular brachytherapy - removal of radioactive scleral plaque	No		

RECONSTRUCTIVE SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Breast Reconstruction	4476	Unilateral mastopexy (at same operative session as any surgery on the opposite breast)	No		Benefit is payable in full with code for the primary procedure
Breast Reconstruction	4477	Breast reconstruction with free flap, post-mastectomy DIEP (deep inferior epigastric perforators) - single surgeon - harvest and reconstruction (I.P.)	Yes	Independent Procedure	
Breast Reconstruction	4478	Breast reconstruction with pedicled transverse rectus abdominis myocutaneous flap (TRAM) (I.P.)	No	Independent Procedure	
Breast Reconstruction	4479	Nipple reconstruction post mastectomy	No	Day Care	
Breast Reconstruction	4480	Breast reduction (unilateral)	Yes		Benefit for payment for breast reduction will be provided in the following circumstances: (a) BMI < 25 (b) Bra cup size ≥ F (c) Symptoms: (i) Back pain, either thoracic or cervical, that has persisted for at least a continuous three month period and has been severe enough to require daily use of prescription analgesia for at least four weeks (ii) Acromio-clavicular syndrome
Breast Reconstruction	4482	Plastic repair of inverted nipple	No	Day Care	
Breast Reconstruction	4484	Unilateral mastopexy in a delayed setting	No		Post Mastectomy Only
Breast Reconstruction	4485	Breast reconstruction, vertical rectus flap, post mastectomy (I.P.)	No	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	4486	Breast reconstruction, latissimus dorsi flap, with or without implant, post mastectomy (unilateral) (I.P.)	No	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	4487	Breast reconstruction, other flap, with or without implant, post mastectomy (I.P.)	No	Independent Procedure	Post Mastectomy Only

RECONSTRUCTIVE SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Breast Reconstruction	4488	Mammoplasty, augmentation with prosthetic implant to restore symmetry	Yes		Benefit for corrective surgery for breast asymmetry will be provided in the following circumstances: (a) Poland's syndrome i.e. where there is absence or hypoplasia of one or both breasts, and an absence/ underdevelopment of one of the major chest muscles (b) Restoration of symmetry following mastectomy
Breast Reconstruction	4554	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	No		
Breast Reconstruction	4556	Delayed (or immediate by a second surgeon at the time of the primary surgery) insertion of breast prosthesis or expander (includes subsequent expansions) following mastopexy, mastectomy or in reconstruction (I.P.)	No	Independent Procedure	
Breast Reconstruction	4557	Replacement of tissue expander with permanent prosthesis (I.P.)	No	Independent Procedure	
Breast Reconstruction	44480	Breast reduction (bilateral)	Yes		Benefit for payment for breast reduction will be provided in the following circumstances: (a) BMI < 25 (b) Bra cup size >/=F (c) Symptoms: (i) Back pain, either thoracic or cervical, that has persisted for at least a continuous three month period and has been severe enough to require daily use of prescription analgesia for at least four weeks (ii) Acromio-clavicular syndrome
Breast Reconstruction	44771	Flap implantation for breast reconstruction with free flap, post-mastectomy DIEP (deep inferior epigastric perforators) - dual surgeons (I.P.)	Yes	Independent Procedure	Paid at 100% in conjunction with code 44772
Breast Reconstruction	44773	Free fat injection, post mastectomy (I.P.)	Yes	Independent Procedure	For correction of breast defect post breast reconstruction surgery (non cosmetic). Limit of 3 per lifetime, per breast
Breast Reconstruction	430311	Lipofilling	Yes		
Breast Reconstruction	441192	Partial reconstruction of breast with pedicaled perforator flap (PLCAP; TDAP etc.)	Yes		Post Mastectomy Only
Breast Reconstruction	441193	Local mobilisation of glandular breast tissue to fill surgical cavity	Yes		Post Mastectomy Only
Breast Reconstruction	441506	Breast reconstruction, latissimus dorsi flap, with or without implant, post mastectomy (bilateral)	No		Post Mastectomy Only
Breast Reconstruction	444466	Bilateral breast reconstruction using fixed prosthesis and acellular dermal matrix (ADM) (I.P.)	Yes	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	444467	Bilateral breast reconstruction using acellular dermal matrix (ADM) (I.P.)	Yes	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	444468	Unilateral breast reconstruction using fixed prosthesis and acellular dermal matrix (ADM) (I.P.)	Yes	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	444469	Unilateral breast reconstruction using acellular dermal matrix (ADM) (I.P.)	Yes	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	444471	TUG flap breast reconstruction procedure, including flap harvesting from both inner thighs (for bilateral reconstruction) and tissue transfer along with the gracilis muscle (I.P.)	Yes	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	444472	PAP flap breast reconstruction procedure including flap harvesting from both inner thighs (bilateral reconstruction) (I.P.)	Yes	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	444473	PAP flap breast reconstruction procedure including flap harvesting from one inner thighs (for unilateral reconstruction) (I.P.)	Yes	Independent Procedure	Post Mastectomy Only

RECONSTRUCTIVE SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Breast Reconstruction	444474	TUG flap breast reconstruction procedure, including flap harvesting from one inner thighs (for unilateral reconstruction) and tissue transfer along with the gracilis muscle (I.P.)	Yes	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	444476	Combined mastopexy to contralateral breast including full thickness graft from other areas and mastopexy including full thickness graft from other areas post mastectomy at same session (I.P.)	Yes	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	444673	Breast reconstruction pedicle performation flap - single surgeon - harvest and reconstruction (I.P.)	Yes	Independent Procedure	Post Mastectomy Only
Breast Reconstruction	444800	Co-surgery benefit for two surgeons who perform complex breast flap surgery (bilateral) including flap raising and vessel harvesting, for a theatre session in excess of 6 hours - for each hour in excess of 6 hours base (I.P.) - Plastic or Breast surgeons benefit	No		
Burns/ Wounds	4337	Debridement of wound, which may include skin, or subcutaneous tissue or muscle less than 9% of body surface	No		
Burns/ Wounds	4338	Debridement of wound, which may include skin, or subcutaneous tissue or muscle between 9% and 18% of body surface	No		
Burns/ Wounds	4339	Debridement of wound includes skin, and/ or subcutaneous tissue, and/ or muscle greater than 18% of body surface	No		
Burns/ Wounds	4341	Debridement and skin grafting of wound less than 9% of body surface; includes excision of open wound, burn eschar or scar excision	No		
Burns/ Wounds	4342	Debridement and skin grafting of wound between 9% and 18% of body surface; includes excision of open wound, burn eschar or scar excision	No		
Burns/ Wounds	4343	Debridement and skin grafting of wound greater than 18% of body surface; includes excision of open wound, burn eschar or scar excision	No		
Burns/ Wounds	4371	Escharotomy	No		
Burns/ Wounds	4372	Acellular dermal replacement; first 100 sq.cm. or less, or 1% of body area of infants and children	No		For codes 4372 and 4373 a comprehensive report must be provided on the claim form detailing body area and square cm involved
Burns/ Wounds	4373	Acellular dermal replacement; each additional 100 sq. cm. or each additional 1% of body area of infants and children	No		For codes 4372 and 4373 a comprehensive report must be provided on the claim form detailing body area and square cm involved
Burns/ Wounds	4385	Inlay grafts (ankle)	No		
Burns/ Wounds	4395	Inlay grafts (fingers)	No		
Burns/ Wounds	4400	Inlay grafts (knee)	No		
Burns/ Wounds	4405	Scar excisions (per scar) flexion, fingers, elbows, groin, knees	No	Day Care	
Burns/ Wounds	4410	Z plasty (per scar) flexion, fingers, elbows, groin, knees	No	Day Care	
Burns/ Wounds	4538	Treatment of superficial wound dehiscence; simple closure with or without packing (single layer closure)	No		
Burns/ Wounds	4539	Secondary closure of wound or dehiscence, as a result of burn, includes excision of granulation and scar tissue; suturing in several layers, extensive site (I.P.)	No	Independent Procedure	
Burns/ Wounds	4541	Skin grafting of granulating wound less than 9% of body surface	No		
Burns/ Wounds	4542	Skin grafting of wound between 9% and 18% of body surface	No		
Burns/ Wounds	4543	Skin grafting of wound greater than 18% of body surface	No		

RECONSTRUCTIVE SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Burns/ Wounds	212013	Wounds up to 2.5 cm in total length, suture of lacerated or torn facial tissue, single or multi layered closure with or without irrigation or debridement (I.P.)	No	Independent Procedure, Side Room	Benefit payable to Plastic and Reconstructive Surgeons only in a hospital setting
Burns/ Wounds	212014	Wounds from 2.6 cm to 7.5 cm in total length, suture of lacerated or torn facial tissue, single or multi layered closure with or without irrigation or debridement (I.P.)	No	Independent Procedure, Side Room	Benefit payable to Plastic and Reconstructive Surgeons only in a hospital setting
Burns/ Wounds	212015	Wounds greater than 7.5cm in total length, suture of lacerated or torn facial tissue, single or multi layered closure with or without irrigation or debridement (I.P.)	No	Independent Procedure, Side Room	Benefit payable to Plastic and Reconstructive Surgeons only in a hospital setting
Cleft Lip and Palate	4415	Adjustment of lip margin	No		
Cleft Lip and Palate	4420	Adjustment of scars, secondary	No		
Cleft Lip and Palate	4425	Cleft palate reconstruction	No		
Cleft Lip and Palate	4430	Complete cleft lip and anterior palate repair	No		
Cleft Lip and Palate	4431	Primary repair, unilateral cleft lip	No		
Cleft Lip and Palate	4432	Primary repair, bilateral cleft lip	No		
Cleft Lip and Palate	4433	Secondary repair, unilateral cleft lip	No		
Cleft Lip and Palate	4434	Secondary repair, bilateral cleft lip	No	Day Care	
Cleft Lip and Palate	4440	Fistula, secondary closure of	No		
Cleft Lip and Palate	4460	Maxillary bone graft	No		
Cleft Lip and Palate	4465	Nostril margin, secondary correction of	No		
Cleft Lip and Palate	4466	Total cleft rhinoplasty	No		
Cleft Lip and Palate	4470	Pharyngoplasty (not for snoring)	No		
Cleft Lip and Palate	4475	Soft palate partial cleft, reconstruction of	No		
Delayed Facial Reanimation	4493	Excision of facial nerve and graft, sural nerve, greater auricular nerve	No		
Delayed Facial Reanimation	4494	Wedge excision of lower lip to restore oral continence in the presence of facial palsy	No	Side Room	
Delayed Facial Reanimation	4496	Nasolabial skin/ dermal hitch	No		
Delayed Facial Reanimation	4497	Temporalis fascial sling, oral, nasolabial, ocular	No		
Delayed Facial Reanimation	4498	Orbicularis oris hitch	No		
Delayed Facial Reanimation	4499	Masseter to oral angle, digastric to lower lip or temporalis to fascial slings	No		

RECONSTRUCTIVE SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Delayed Facial Reanimation	4500	Facial nerve graft (in face), (see ENT operations for facial nerve graft in facial canal)	No		
Delayed Facial Reanimation	4501	Cross facial nerve grafting, hypoglossal/facial nerve reanimation	No		
Delayed Facial Reanimation	4502	Free muscle transfer, pectoralis minor, gracilis or extensor digitorum brevis as a second stage procedure to code 4501	No		
Delayed Facial Reanimation	4510	Facial reanimation in facial paralysis, unilateral	No		
Ear	4555	Accessory auricles, removal	No	Day Care	
Ear	4560	Epithelioma of ear, excision and reconstruction, lobule placement	No	Side Room	
Ear	4561	Cartilage graft(s), reconstruction of ear	No		
Ear	4575	Protruding ears, correction with reconstruction of folds, bilateral	No	Day Care	Benefit only payable for patients up to eighteen years of age
Ear	4580	Protruding ears, correction of with reconstruction of folds, unilateral	No	Day Care	Benefit only payable for patients up to eighteen years of age
Eyes	4585	Reconstruction of contracted ocular socket	No		
Eyes	4595	Enophthalmos, bone graft	No		
Eyes	4605	Decompression, orbit	No		
Eyes	4610	Eyebrow graft	No		
Eyes	4615	Eyelids, repair of, for avulsion	No		
Eyes	4620	Eyelid, inlay grafts (one lid)	No	Side Room	
Eyes	4625	Eyelid operations in facial paralysis	No		Visual fields must be supplied with claim form
Eyes	4630	Eyelid, reconstruction of less than 66% of surface area	No	Day Care	
Eyes	4635	Muscle advancement for ptosis, unilateral	No	Day Care	
Eyes	4640	Naso lacrimal duct, reconstruction of	No		
Eyes	669911	Eyelid, reconstruction of greater than 66% of surface area	No	Day Care	Documentation required
Eyes	669912	Eyelid, reconstruction of less than 66% of surface area	No	Day Care	Documentation required
Eyes	825013	Lateral canthopexy	No		
Facial Trauma	4489	Facial trauma, suturing of facial nerve	No		
Facial Trauma	4491	Facial trauma, suturing of facial nerve branch	No		
Facial Trauma	4492	Facial trauma, grafting of facial nerve, sural nerve, greater auricular nerve	No		
Flaps and/ or Grafts	4513	Free skin and/ or muscle flap with microvascular anastomosis	No		
Flaps and/ or Grafts	4514	Free osteocutaneous flap with microvascular anastomosis, any area	No		

RECONSTRUCTIVE SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Flaps and/ or Grafts	4939	Excision of benign or malignant lesion(s), any area; adjacent tissue transfers or rearrangement, for wounds requiring extensive (>3cm) undermining of skin edges for effective closure	No	Day Care	Procedure codes 4937, 4938, 4939, 4941, 4942, 4943 and 4946 are only payable to consultants Plastic Surgeons
Flaps and/ or Grafts	4941	Excision of benign or malignant lesion(s), any area; adjacent tissue transfer or rearrangement, for wounds with significant (>3cm) of overhanging skin flaps after excision of lesion or mass	No	Day Care	Procedure codes 4937, 4938, 4939, 4941, 4942, 4943 and 4946 are only payable to consultants Plastic Surgeons
Flaps and/ or Grafts	4942	Skin graft (pinch, split thickness, epidermal, dermal or tissue culture or free flap excised from a distant site and harvested as a graft from non adjacent skin) for repair when direct wound closure or adjacent tissue transfer is not possible; with codes 4937 or 4938. (List separately in addition to code for primary procedure. Benefit shown is payable in full with code for the primary procedure)	No		Procedure codes 4937, 4938, 4939, 4941, 4942, 4943 and 4946 are only payable to consultants Plastic Surgeons
Flaps and/ or Grafts	4943	Skin graft (pinch, split thickness, epidermal, dermal or tissue culture or free flap excised from a distant site and harvested as a graft from non adjacent skin) for repair when direct wound closure or adjacent tissue transfer is not possible; with code 4939. (List separately in addition to code for primary procedure. Benefit shown is payable in full with code for the primary procedure) (see note after procedure 4946)	No		Procedure codes 4937, 4938, 4939, 4941, 4942, 4943 and 4946 are only payable to consultants Plastic Surgeons
Flaps and/ or Grafts	4944	Excision of pressure sore and myocutaneous flap	No		Payable in full with primary procedure
Flaps and/ or Grafts	4946	Skin graft (pinch, split thickness, epidermal, dermal or tissue culture or free flap excised from a distant site and harvested as a graft from non adjacent skin) for repair when direct wound closure or adjacent tissue transfer is not possible; with code 4941. (List separately in addition to code for primary procedure. Benefit shown is payable in full with code for the primary procedure) (see procedure code 4946)	No		Procedure codes 4937, 4938, 4939, 4941, 4942, 4943 and 4946 are only payable to consultants Plastic Surgeons
Flaps and/ or Grafts	4949	Excision of pressure sore and local cutaneous flap (I.P.)	No	Independent Procedure	
Flaps and/ or Grafts	4951	Free flap (microvascular transfer) to face, complete procedure	No		
Flaps and/ or Grafts	4952	Excision or debridement of pressure sore and split skin graft (I.P.)	No	Independent Procedure	
Flaps and/ or Grafts	4963	Excision of lesion including scalp rotation flap (I.P.)	No	Independent Procedure, Day Care	Independent Procedure rule does not apply when code 4963 is done in combination with code 4966
Flaps and/ or Grafts	4964	Excision of lesion including cheek rotation flap (I.P.)	No	Independent Procedure, Day Care	
Flaps and/ or Grafts	4966	Excision of lesion including cervicofacial rotation flap (I.P.)	No	Independent Procedure, Day Care	Independent Procedure rule does not apply when code 4966 is done in combination with code 4963
Flaps and/ or Grafts	4967	Excision of lesion including forehead flap (I.P.)	No	Independent Procedure, Day Care	
Flaps and/ or Grafts	4968	Excision of lesion including deltopectoral flap (I.P.)	No	Independent Procedure	
Flaps and/ or Grafts	4969	Excision of lesion including groin flap (I.P.)	No	Independent Procedure	
Flaps and/ or Grafts	4971	Fasciocutaneous flap, upper limb (I.P.)	No	Independent Procedure	
Flaps and/ or Grafts	4972	Fasciocutaneous flap, lower limb (I.P.)	No	Independent Procedure	

RECONSTRUCTIVE SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Flaps and/ or Grafts	4973	Fasciocutaneous flap, trunk (I.P.)	No	Independent Procedure	
Flaps and/ or Grafts	4974	Myocutaneous flap, pectoralis	No		Payable in full with primary procedure
Flaps and/ or Grafts	4976	Myocutaneous flap, latissimus dorsi	No		Payable in full with primary procedure
Flaps and/ or Grafts	4977	Myocutaneous flap, latissimus dorsi with serratus and rib	No		Payable in full with primary procedure
Flaps and/ or Grafts	4978	Myocutaneous flap, vertical rectus	No		Payable in full with primary procedure
Flaps and/ or Grafts	4979	Myocutaneous flap, transverse rectus (TRAM)	No		Payable in full with primary procedure
Flaps and/ or Grafts	4981	Myocutaneous flap, tensor fascia lata	No		Payable in full with primary procedure
Flaps and/ or Grafts	4982	Myocutaneous flap, gluteal	No		Payable in full with primary procedure
Genitalia	4686	Cliteroplasty	No		
Genitalia	4690	Vaginal reconstruction with skin graft	No		
Hand	4695	Congenital hand deformities, reconstruction on each hand (per stage)	No		
Hand	4700	Congenital hand deformities, moderate repairs on each hand (per stage)	No	Day Care	
Hand	4705	Contractures, extensive, straightening of hand and inlay grafts	No		
Hand	4710	Contractures, localised, division and graft	No		
Hand	4711	Dermofasciectomy, removal of flexor skin, full thickness skin graft including distal or full palm, one finger	No		
Hand	4712	Dermofasciectomy, removal of flexor skin, full thickness skin graft including distal or full palm, one finger including simple fasciectomy to another finger	No		
Hand	4715	Dupuytren's contracture, fasciectomy (one or two fingers)	No	Day Care	
Hand	4720	Dupuytren's contracture, fasciectomy (three or more fingers)	No	Day Care	
Hand	4721	Dupuytren's contracture, palm and fingers	No	Day Care	
Hand	4730	Injury to hand, major, multiple repair of tendons, nerves and skin	No		
Hand	4735	Injury to hand, moderate, wound repair or graft	No		
Hand	4740	Island grafting, for sensory loss, finger and/ or thumb	No		
Hand	4745	Neoplasm, major excision and repair with tendon grafts and flaps	No		
Hand	4750	Neoplasm, localised excision and graft	No	Day Care	
Hand	4760	Nerve repair, primary, single or multiple	No	Day Care	
Hand	4765	Nerve repair in extensively scarred hand	No		
Hand	4770	Opposition strut graft to thumb	No		
Hand	4775	Palmar ganglion, compound, synovectomy of	No	Day Care	
Hand	4780	Pollicisation (finger replacement of lost thumb)	No		

RECONSTRUCTIVE SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Hand	4781	Repair of bifid thumb	No		
Hand	4782	Toe to hand transfer	No		
Hand	4783	Sympathectomy, digital arteries, each digit with magnification	No		
Hand	4785	Syndactyly, repair of, single	No		
Hand	4790	Syndactyly, repair of, multiple	No		
Hand	4795	Tendon grafting, single	No		
Hand	4800	Tendon grafting, multiple	No	Day Care	
Hand	4805	Tendon repair, single	No		
Hand	4810	Tendon repair, multiple	No		
Hand	4815	Tendon transplants, for restoration of opposition	No		
Hand	4820	Tendon transfers for paralysis, multiple	No		
Hand	4825	Tube pedicle or flap reconstructions, first stage	No		
Hand	4830	Tube pedicle or flap reconstructions, second stage	No		
Hand	4835	Tube pedicle or flap reconstructions, final stage	No		
Maxilla and Mandible	4845	Facial bone, simple fixation of undisplaced fracture (e.g. jaw sling)	No		
Maxilla and Mandible	4850	Facial bones, tumours of, major resection and/ or reconstruction	No		
Maxilla and Mandible	4855	Fracture of maxilla or mandible, open reduction and fixation	No		
Maxilla and Mandible	4860	Fracture of maxilla or mandible, fixation of undisplaced	No		
Maxilla and Mandible	4865	Fracture of maxilla or mandible, malar bone or part of these, reduction without fixation	No		
Maxilla and Mandible	4870	Hypertelorism correction, sub cranial	No		
Maxilla and Mandible	4875	Mandible, excision of	No		
Maxilla and Mandible	4880	Maxilla or mandible, advancement or recession osteotomy of	No		
Maxilla and Mandible	4881	Maxillary and mandibular osteotomy	No		
Maxilla and Mandible	4882	Lengthening of the mandible by gradual distraction for congenital hemifacial microsomia	Yes		
Maxilla and Mandible	4883	Surgically assisted rapid maxillary expansion	Yes		
Maxilla and Mandible	4885	Orbital floor, fracture of, reduction, direct wiring and build up from antrum	No		
Maxilla and Mandible	4890	Orbital floor, secondary bone grafting	No		
Maxilla and Mandible	4895	Osteomyelitis or abscess of facial bones, operation for	No	Day Care	
Maxilla and Mandible	4900	Temporo mandibular joint, reduction of dislocation under general anaesthetic	No	Day Care	

RECONSTRUCTIVE SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Maxilla and Mandible	4901	Arthroscopy, temporo mandibular joint for release of adhesions or arthroplasty, with or without biopsy	No	Day Care	
Maxilla and Mandible	4905	Temporo mandibular joint, condylectomy for ankylosis	No		
Nose	4910	Bone graft	No		
Nose	4915	Nasal tip deformities, correction of	No		
Nose	4920	Fracture of nose, digital closed reduction	No	Day Care	
Nose	4925	Fracture of nose, instrumental closed reduction	No	Day Care	
Nose	4926	Fracture of nose, instrumental closed reduction with plaster of paris fixation	No	Day Care	
Nose	4927	Fracture of nose, instrumental closed reduction with reduction of septum and plaster of paris fixation	No	Day Care	
Nose	4930	Fracture of nose, open reduction	No	Day Care	
Nose	4935	Fracture of nose, open reduction with internal or external fixation	No	Day Care	
Nose	4940	Fracture of nose, open reduction with open reduction of fractured septum	No	Day Care	
Nose	4945	Reconstruction with imported flaps, partial	No	Day Care	
Nose	4950	Reconstruction with imported flaps, total	No		
Nose	4955	Re-fracture and open corrective rhinoplasty including nasal tip deformities (code 4915), unless demonstrable evidence discloses significant nasal tip deformity being corrected (I.P.)	No	Independent Procedure, Day Care	
Nose	30120	Rhinophyma (I.P.)	Yes	Independent Procedure	Supported by a consultant report and photographic evidence
Other Reconstructive Procedures	3061	Giant cell tumour, excision of primary or recurrent lesion from bone or soft tissue (I.P.)	No	Independent Procedure	
Other Reconstructive Procedures	4547	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen; infraumbilical panniculectomy	Yes		Benefit is payable for procedure code 4547 only in the following circumstances: (a) For members who have had bariatric surgery for which Irish Life Health have paid benefit and (b) Where the panniculus hangs below the level of the pubis; and the medical records document that the panniculus causes chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing) that consistently recurs over 3 months while receiving appropriate medical therapy, or remains refractory to appropriate medical therapy over a period of 3 months Pre certification required
Other Reconstructive Procedures	4836	Release of syndactyly; toes (I.P.)	No	Independent Procedure	
Other Reconstructive Procedures	4947	Large lipoma > 4 cm in diameter, requiring removal under general anaesthetic, deep to deep fascia requiring surgery by consultant Plastic Surgeon	No		1 Night Only
Other Reconstructive Procedures	4990	Major degloving injuries of limbs, excision and graft of	No		
Other Reconstructive Procedures	5630	Repair of cirsoid aneurysm of the scalp	No		
Other Reconstructive Procedures	825011	Removal by contouring of benign tumour of facial bone (e.g. fibrous dysplasia)	No		

RECONSTRUCTIVE SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Replantation	4991	Replantation, per digit	No		
Replantation	4992	Replantation, hand (mid palm)	No		
Replantation	4993	Replantation, hand (wrist)	No		
Replantation	4994	Replantation, forearm	No		
Replantation	4996	Replantation, foot	No		
Replantation	4997	Replantation, scalp following major trauma only	No		
Replantation	4998	Replantation, ear	No		
Replantation	4999	Replantation of thumb including carpometacarpal joint to metacarpophalangeal joint, complete amputation, with or without microvascular anastomosis	No		
Tissue Expanders	4551	Insertion of tissue expanders (other than breast) includes subsequent expansion(s)	No		
Tissue Expanders	4552	Removal of expander (other than breast)	No		
Tissue Expanders	4553	Removal of expander (other than breast) and inserting of expanded skin	No		

SPINAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Aspiration/ Biopsy	3566	Neural arch biopsy	No		
Aspiration/ Biopsy	227072	Needle aspiration of intervertebral disc	No		
Decompression/ Discectomy	3525	Anterolateral decompression	No		
Decompression/ Discectomy	3526	Anterolateral decompression involving two or more levels	No		
Decompression/ Discectomy	3560	Intervertebral disc, removal of	No		
Decompression/ Discectomy	3563	Excision of thoracic intervertebral disc	No		
Decompression/ Discectomy	3603	Spinal stenosis decompression, one level	No		
Decompression/ Discectomy	3604	Spinal stenosis decompression, two levels	No		
Decompression/ Discectomy	5937	Discectomy, anterior, with decompression of spinal cord and/ or nerve root(s), including osteophytectomy; cervical	No		
Decompression/ Discectomy	227001	Spinal decompression and/ or discectomy, single level unilateral, any region, posterior approach	No		Codes 227001 - 227015 cannot be used in combination with fusion codes

SPINAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Decompression/ Discectomy	227002	Spinal decompression and/ or discectomy, single level bilateral or more than one level, any region, posterior approach	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227003	Revision spinal decompression and/ or discectomy, any region, posterior approach	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227004	Far lateral/ extraforaminal decompression and/ or discectomy, lumbar	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227005	Costovertebral approach with decompression of the spinal cord and/ or nerve roots, thoracic	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227006	Anterior thoracic discectomy or partial discectomy, single level, this includes decompression of the spinal cord and/ or nerve root(s)	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227007	Anterior thoracic discectomy or partial discectomy, more than one level, this includes decompression of the spinal cord and/ or nerve root(s)	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227008	Anterior cervical discectomy or partial discectomy, single level, this includes decompression of the spinal cord and/ or nerve root(s)	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227009	Anterior cervical discectomy or partial discectomy, more than one level, this includes decompression of the spinal cord and/ or nerve root(s)	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227010	Spinal decompression and/ or discectomy, single level unilateral with interspinous dynamic stabilization implant	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227011	Spinal decompression and/ or discectomy, single level bilateral or at more than one level with interspinous dynamic stabilization implant	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227012	Revision spinal decompression and/ or discectomy, single level unilateral, bilateral or at more than one level with interspinous dynamic stabilization implant	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Decompression/ Discectomy	227016	Vertebral corpectomy, including decompression of spinal cord and or nerve roots, single level	No	This code can be combined with fusion codes and fusion modifiers	
Decompression/ Discectomy	227017	Vertebral corpectomy, including decompression of spinal cord and or nerve roots, more than one level	No	This code can be combined with fusion codes and fusion modifiers	
Disc Replacement	227035	Total disc replacement, lumbar, single level	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed

SPINAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Disc Replacement	227036	Total disc replacement, cervical, single level	No		This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed
Disc Replacement	227037	Total disc replacement, any location, each additional level	No		This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed
Interspinous Stabilisation	227013	Dynamic interspinous stabilisation without direct decompression, single level (I.P.)	No	Independent Procedure	Codes 227001 - 227015 cannot be used in combination with fusion codes
Interspinous Stabilisation	227014	Dynamic interspinous stabilisation without direct decompression, more than one level	No		Codes 227001 - 227015 cannot be used in combination with fusion codes
Laminectomy	3565	Laminectomy and exploration with or without rhizotomy	No		
Laminectomy	5979	Laminectomy for implantation of neurostimulator electrodes, plate/ paddle, epidural	No		
Laminectomy	227065	Laminectomy with drainage of intramedullary cyst/ syrinx	No		
Laminectomy	227066	Laminectomy with release of tethered spinal cord	No		
Laminectomy	227067	Laminectomy for excision/ occlusion of arteriovenous malformation of spinal cord	No		
Osteotomy	227044	Chevron osteotomy, any region, single level	No	Fusion modifiers (payable at 100% each)	
Osteotomy	227045	Chevron osteotomy, any region, more than one level	No	Fusion modifiers (payable at 100% each)	
Osteotomy	227046	Pedicle subtraction osteotomy, any region, single level	No	Fusion modifiers (payable at 100% each)	
Osteotomy	227047	Pedicle subtraction osteotomy, any region, more than one level	No	Fusion modifiers (payable at 100% each)	
Other Spinal Procedures	3520	Anterior drainage of paravertebral abscess with bone graft	No		
Other Spinal Procedures	3592	External fixture of the spine	No		
Other Spinal Procedures	4271	Costotransversectomy	No		
Other Spinal Procedures	5964	Each additional interspace, cervical	No		
Other Spinal Procedures	5981	Neuroplasty and/ or transposition ulnar nerve	No	Day Care	
Other Spinal Procedures	227015	Cervical spine laminoplasty with segmental plate fixation (I.P.)	No	Independent Procedure	Codes 227001 - 227015 cannot be used in combination with fusion codes
Other Spinal Procedures	227048	Vertebral column resection	No	Fusion modifiers (payable at 100% each)	

SPINAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Other Spinal Procedures	227064	CSF leak repair (I.P.)	No	Independent Procedure	
Other Spinal Procedures	227069	Coccygectomy	No		
Other Spinal Procedures	227070	Vertebral body biopsy	No	Diagnostic	
Other Spinal Procedures	227071	Spinal manipulation, under general anaesthetic	No		
Other Spinal Procedures	227073	Drainage/ debridement of spinal abscess	No		
Removal of Instrumentation	227062	Removal of spinal instrumentation via an anterior approach, all levels and locations	No		
Removal of Instrumentation	227063	Removal of spinal instrumentation via a posterior approach, all levels and locations	No		
Spina Bifida	3580	Spina bifida, closure of	No		
Spina Bifida	3585	Spina bifida, lumbar spinal osteotomy (may include spinal chevron osteotomy up to 5 levels)	No		Codes for Spina Bifida cannot be charged together in any one specific case
Spina Bifida	35851	Spina bifida, lumbar spinal osteotomy (may include spinal chevron osteotomy more than 5 levels)	No		Codes for Spina Bifida cannot be charged together in any one specific case
Spina Bifida	227068	Repair of meningocoele/ myelomeningocoele	No		
Spinal Fracture	227049	Fractured spine, open or percutaneous reduction or, including spinal canal clearance of bony and/ or disc material, one or two levels	No	Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fracture	227050	Fractured spine, open or percutaneous reduction or, including spinal canal clearance of bony and/ or disc material, more than two levels	No	Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fracture	227051	Anterior retropharyngeal approach and open reduction of odontoid fracture	No	Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fracture	227052	Closed reduction of spinal fracture and application of halo jacket or equivalent (I.P.)	No	Independent Procedure	

SPINAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Spinal Fracture	227053	Closed reduction of spinal fracture and application of skull traction (I.P.)	No	Independent Procedure	
Spinal Fusion	3521	Anterior release and fusion for scoliosis/ kyphosis	No		
Spinal Fusion	3571	Posterior spinal fusion with instrumentation for scoliosis (up to 8 levels)	No		Codes for scoliosis cannot be charged together in any one specific case
Spinal Fusion	3586	Spinal fusion, simultaneous combined anterior and posterior fusion, one level, with instrumentation (insertion of rods, plates and/ or screws and/ or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer)	No		
Spinal Fusion	3587	Spinal fusion, simultaneous combined anterior and posterior fusion, multiple level, with instrumentation (insertion of rods, plates and/ or screws and/ or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer) up to 3 levels	No		Codes 3587, 35871 and 35872 cannot be charged together in any one specific case
Spinal Fusion	3588	Spinal fusion, simultaneous combined anterior and posterior fusion, one level, without instrumentation	No		
Spinal Fusion	3589	Spinal fusion, simultaneous combined anterior and posterior fusion, multiple level, without instrumentation	No		
Spinal Fusion	3595	Spinal fusion	No		
Spinal Fusion	3596	Spinal fusion, in scoliosis spine, anterior and posterior	No		
Spinal Fusion	3597	Spinal fusion involving two or more levels	No		
Spinal Fusion	3598	Spinal fusion, multiple level, with internal fixation (insertion of rods, plates and/ or screws and/ or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer) – up to 3 levels	No		Codes 3598, 35981 and 35982 cannot be charged together in any one specific case
Spinal Fusion	3601	Spinal fusion, one level with instrumentation (insertion of rods, plates and/ or screws and/ or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer)	No		
Spinal Fusion	5799	Arthrodesis, anterior interbody fusion (ALIF)	No		
Spinal Fusion	5929	Arthrodesis, posterior interbody fusion (PLIF) including the insertion of interbody cage	No		
Spinal Fusion	35711	Posterior spinal fusion with instrumentation for scoliosis (over 8 levels)	No		Codes for scoliosis cannot be charged together in any one specific case
Spinal Fusion	35871	Spinal fusion, simultaneous combined anterior and posterior fusion, multiple level, with instrumentation (insertion of rods, plates and/ or screws and/ or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer) up to 4 to 8 levels (I.P.)	No	Independent Procedure	Codes 3587, 35871 and 35872 cannot be charged together in any one specific case
Spinal Fusion	35872	Spinal fusion, simultaneous combined anterior and posterior fusion, multiple level, with instrumentation (insertion of rods, plates and/ or screws and/ or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer) over 8 levels (I.P.)	No	Independent Procedure	Codes 3587, 35871 and 35872 cannot be charged together in any one specific case
Spinal Fusion	35981	Spinal fusion, multiple level, with internal fixation (insertion of rods, plates and/ or screws and/ or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer) – 4 to 8 levels (I.P.)	No	Independent Procedure	Codes 3598, 35981 and 35982 cannot be charged together in any one specific case
Spinal Fusion	35982	Spinal fusion, multiple level, with internal fixation (insertion of rods, plates and/ or screws and/ or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer) – over 8 levels (I.P.)	No	Independent Procedure	Codes 3598, 35981 and 35982 cannot be charged together in any one specific case

SPINAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Spinal Fusion	227018	Thoracic or lumbar spinal fusion (180 degree), single level - all posterior approaches with posterior and/ or posterolateral and/ or facet fusion or interbody fusion (PLIF/ TLIF)	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fusion	227019	Thoracic or lumbar spinal fusion (180 degree), two levels - all posterior approaches with posterior and/ or posterolateral and/ or facet fusion or interbody fusion (PLIF/ TLIF)	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fusion	227020	Thoracic or lumbar spinal fusion (180 degree), three or more levels - all posterior approaches with posterior and/ or posterolateral and/ or facet fusion or interbody fusion (PLIF/ TLIF)	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fusion	227021	Thoracic or lumbar spinal fusion (360 degree), single level - all posterior approaches with posterior and/ or posterolateral and/ or facet fusion or interbody fusion (PLIF/ TLIF)	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	

SPINAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Spinal Fusion	227022	Thoracic or lumbar spinal fusion (360 degree), two levels - all posterior approaches with posterior and/or posterolateral and/or facet fusion or interbody fusion (PLIF/TLIF)	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fusion	227023	Thoracic or lumbar spinal fusion (360 degree), three or more levels - all posterior approaches with posterior and/ or posterolateral and/ or facet fusion or interbody fusion (PLIF/ TLIF)	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fusion	227024	Anterior cervical spinal fusion, single level	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fusion	227025	Anterior/ anterolateral/ lateral thoracic spinal fusion, single level	No		This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used
Spinal Fusion	227026	Anterior/ anterolateral/ lateral lumbar spinal fusion, single level - Includes ALIF/ OLIF/ XLIF	No		This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used

SPINAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Spinal Fusion	227027	Anterior/ anterolateral/ lateral spinal fusion, single additional level	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	Payable in full in addition to single level code and fusion modifier codes
Spinal Fusion	227028	Anterior/ anterolateral/ lateral spinal fusion, two additional levels	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	Payable in full in addition to single level code and fusion modifier codes
Spinal Fusion	227029	Anterior/ anterolateral/ lateral spinal fusion, three or more additional levels	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	Payable in full in addition to single level code and fusion modifier codes
Spinal Fusion	227030	Posterior cervical fusion, single level	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	

SPINAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Spinal Fusion	227031	Posterior cervical fusion, two levels	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fusion	227032	Posterior cervical fusion, three or more levels level	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fusion	227033	Occipitocervical fusion or atlantoaxial fusion	No	This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed. Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used	
Spinal Fusion	227034	Sacroiliac joint fusion	No		This is inclusive of spinal canal/ nerve root decompression/ discectomy if performed Fusion modifier codes can be added where appropriate and are payable at 100% for each and every code used
Spinal Fusion	647012	Co-surgery benefit for vascular surgeon who assists in ALIF spinal surgery (I.P.)	Yes	Independent procedure	Claimable by vascular surgeon assisting in ALIF spinal surgery procedure
Tumours	5934	Removal of spinal bone tumours	No		
Tumours	5976	Laminectomy for removal/ biopsy extramedullary tumour	No		
Tumours	5977	Laminectomy for removal/ biopsy intramedullary tumour	No		

SPINAL SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Tumours	227056	Excision, partial or total, of extradural spinal tumour, any location	No		In cases where spinal fusion and instrumentation are required in addition to tumour removal then the appropriate fusion code can be used along with appropriate fusion modifiers The fusion code or the tumour excision code may be used as the primary code depending on which is of greatest value, the other code is then payable at 50%, however the modifier codes are all payable at 100%
Tumours	227057	Excision, partial or total, of intradural but extramedullary spinal tumour, any location	No		In cases where spinal fusion and instrumentation are required in addition to tumour removal then the appropriate fusion code can be used along with appropriate fusion modifiers The fusion code or the tumour excision code may be used as the primary code depending on which is of greatest value, the other code is then payable at 50%, however the modifier codes are all payable at 100%
Tumours	227058	Excision, partial or total, of intramedullary spinal tumour, any location	No		In cases where spinal fusion and instrumentation are required in addition to tumour removal then the appropriate fusion code can be used along with appropriate fusion modifiers The fusion code or the tumour excision code may be used as the primary code depending on which is of greatest value, the other code is then payable at 50%, however the modifier codes are all payable at 100%
Tumours	227059	Excision, partial or total, of combined intradural and extradural spinal tumour, any location	No		In cases where spinal fusion and instrumentation are required in addition to tumour removal then the appropriate fusion code can be used along with appropriate fusion modifiers The fusion code or the tumour excision code may be used as the primary code depending on which is of greatest value, the other code is then payable at 50%, however the modifier codes are all payable at 100%
Tumours	227060	Sacrectomy, partial of total, for spinal tumour	No		In cases where spinal fusion and instrumentation are required in addition to tumour removal then the appropriate fusion code can be used along with appropriate fusion modifiers The fusion code or the tumour excision code may be used as the primary code depending on which is of greatest value, the other code is then payable at 50%, however the modifier codes are all payable at 100%
Tumours	227061	Laminectomy and biopsy of intradural tumour	No		In cases where spinal fusion and instrumentation are required in addition to tumour removal then the appropriate fusion code can be used along with appropriate fusion modifiers The fusion code or the tumour excision code may be used as the primary code depending on which is of greatest value, the other code is then payable at 50%, however the modifier codes are all payable at 100%
Vertebral Augmentation	227054	Percutaneous vertebral augmentation with or without use of mechanical device, single level, lumbar	No		
Vertebral Augmentation	227055	Percutaneous vertebral augmentation with or without use of mechanical device, single level, thoracic	No		
Vertebroplasty	3606	Percutaneous vertebroplasty, single thoracic vertebra (may include balloon kyphoplasty)	No		
Vertebroplasty	3607	Percutaneous vertebroplasty, single lumbar vertebra (may include balloon kyphoplasty)	No		

THORACIC SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Atria	5208	Left atrial appendage occlusion (I.P.)	Yes	Independent Procedure	Possible co-payment please check Table of Cover Cover must be requested in advance
Atria	5824	Refashioning of atrium (Ebstein's)	No		Possible co-payment please check Table of Cover
Atria	5826	Operations on wall of atrium	No		Possible co-payment please check Table of Cover

THORACIC SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Atrial Fibrillation	5033	Thoracoscopic epicardial radiofrequency ablation; operative tissue ablation with or without reconstruction of atria (e.g. modified maze procedure) without cardiopulmonary bypass (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover Conditions of payment for code 5033 are as follows: (a) Benefit will be provided for thoracoscopic epicardical radiofrequency ablation for patients with atrial fibrillation who have failed to respond to trans-catheter endocardial ablation provided the decision is the consensus of a multidisciplinary team that includes both a cardiologist and a cardiothoracic surgeon, both with training and experience in the use of intra-operative electrophysiology (b) Relevant documentation confirming the above must be provided when the claim is being submitted
Atrial Fibrillation	5134	Operative ablation/incision and/or reconstruction of atria for treatment of atrial fibrillation or flutter (e.g. maze procedure)	No		Possible co-payment please check Table of Cover
Atrial Fibrillation	5138	Operative ablation of atrial fibrillation, supraventricular arrhythmogenic focus or pathway (e.g. Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/ or focus (foci) with or without cardiopulmonary bypass	No		Possible co-payment please check Table of Cover
Atrial Fibrillation	5139	Operative ablation of atrial fibrillation, ventricular arrhythmogenic focus with cardiopulmonary bypass	No		Possible co-payment please check Table of Cover
Biopsy	5041	Myocardial biopsy	No	Diagnostic	
Biopsy	5124	Mediastinoscopy, without biopsy (I.P.)	No	Independent Procedure, Diagnostic	Possible co-payment please check Table of Cover
Biopsy	5135	Mediastinoscopy and biopsy	No	Diagnostic	Possible co-payment please check Table of Cover
Biopsy	5136	Percutaneous transthoracic biopsy	No	Diagnostic	
Biopsy	5137	Percutaneous transthoracic biopsy under CAT guidance	No	Diagnostic	
Biopsy	5218	Needle biopsy, abdominal	No	Diagnostic	
Bronchi/ Lungs/ Pleura	5025	Pneumonolysis	No		Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5230	Empyema, drainage of (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5245	Phrenic avulsion (I.P.)	No	Independent Procedure	
Bronchi/ Lungs/ Pleura	5250	Pleurodesis (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5260	Thoracoscopy (I.P.)	No	Independent Procedure, Diagnostic	Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5265	Thoracoscopy with intrapleural procedure (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5928	Therapeutic operations on bronchus or lung using rigid bronchoscopy	No	Diagnostic	
Bronchi/ Lungs/ Pleura	5941	Total pneumonectomy	No		Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5942	Lobectomy of lung (including excision of segment)	No		Possible co-payment please check Table of Cover

THORACIC SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Bronchi/ Lungs/ Pleura	5943	Thoracoscopic lung resections, includes robotic approach (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5944	Open excision of lesion of lung	No		Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5946	Decortication of pleura or lung, open or thorascopic (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5947	Removal of lung, with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)	No		Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5948	Removal of lung, with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)	No		Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5949	Pleurectomy for pneumothorax, open	No		Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5951	Endoscopic examination of pleura (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5982	Total pneumonectomy with lymphadenectomy	No		Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	5983	Lobectomy of lung (including excision of segment) with lymphadenectomy	No		Possible co-payment please check Table of Cover
Bronchi/ Lungs/ Pleura	328582	Robotically assisted thoracoscopic pneumonectomy, lobectomy (single or bilobar), segmentectomy or LVRS (other than bullectomy)	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Bronchi/ Lungs/ Pleura	328592	Robotically assisted thoracoscopic pneumonectomy, lobectomy (single or bilobar), segmentectomy with regional lymphadenectomy	No		Possible co-payment please check Table of Cover For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Bypass Surgery	5131	Open procurement of a radial artery to secure conduit for construction of a coronary artery bypass graft (payable in full with main benefit)	No		Payable in full with main benefit
Bypass Surgery	5158	Coronary artery bypass grafts using venous graft(s) and/or arterial graft(s)	No		Possible co-payment please check Table of Cover
Bypass Surgery	5168	Revision coronary artery bypass grafts using venous graft(s) and/ or arterial grafts	No		Possible co-payment please check Table of Cover
Bypass Surgery	5867	Removal of pacing system with bypass	No		Possible co-payment please check Table of Cover
Bypass Surgery	5894	Extra anatomic bypass of aorta	No		Possible co-payment please check Table of Cover
Chest Wall	5015	Lung abscess with thoracotomy, drainage of	No		Possible co-payment please check Table of Cover
Chest Wall	5205	Vagotomy (through chest)	No		Possible co-payment please check Table of Cover

THORACIC SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Chest Wall	5270	Thoracotomy including lung or pleural biopsy (I.P.)	No	Independent Procedure, Diagnostic	Possible co-payment please check Table of Cover
Chest Wall	5274	Exploration for post-operative haemorrhage or thrombosis, chest	No		Possible co-payment please check Table of Cover
Chest Wall	5907	Repair of congenital diaphragmatic hernia using thoracic approach in neonates	No		Possible co-payment please check Table of Cover The anaesthetist benefit is all inclusive of pre-operative and post-operative intensive care No other anaesthetic or intensive care benefits are payable
Chest Wall	5908	Thoracoplasty, one stage	No		Possible co-payment please check Table of Cover
Chest Wall	5909	Excision of chest wall tumour including ribs	No		Possible co-payment please check Table of Cover
Chest Wall	5912	Correction of pectus deformity of chest wall	No		Possible co-payment please check Table of Cover
Chest Wall	5913	Reconstruction of chest wall	No		Possible co-payment please check Table of Cover
Chest Wall	5914	Exploratory thoracotomy	No		Possible co-payment please check Table of Cover
Chest Wall	5916	Resection of rib and open drainage of pleural cavity	No		Possible co-payment please check Table of Cover
Chest Wall	5917	Repair of rupture of diaphragm	No		Possible co-payment please check Table of Cover Procedure code 5917 is not payable in conjunction with procedure code 271
Chest Wall	5918	Plication of paralysed diaphragm	No		Possible co-payment please check Table of Cover
Chest Wall	5927	Cervical rib resection for thoracic outlet syndrome	No		Possible co-payment please check Table of Cover
Chest Wall	5963	Repair of diaphragmatic hernia using thoracic approach	No		Possible co-payment please check Table of Cover
Fibreoptic Procedures	5931	Destruction of lesion of trachea	No		
Fibreoptic Procedures	5932	Dilatation of tracheal stricture	No		
Fibreoptic Procedures	5936	Dilatation of bronchial stricture by fibre optic bronchoscopy	No	Diagnostic	
Mediastinum	5110	Thoracoscopy, surgical; with oesophagomyotomy (Heller type)	No		Possible co-payment please check Table of Cover
Mediastinum	5113	Pericardial drainage	No		
Mediastinum	5114	Continuous pericardial drainage	No		
Mediastinum	5120	Excision of mediastinal tumour, includes robotic approach	No		Possible co-payment please check Table of Cover
Mediastinum	5121	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach	No		Possible co-payment please check Table of Cover
Mediastinum	5122	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy	No		Possible co-payment please check Table of Cover
Mediastinum	5123	Excision of mediastinal cyst	No		Possible co-payment please check Table of Cover
Mediastinum	5148	Laparoscopy, surgical, oesophagomyotomy (Heller type) with fundoplasty, when performed	No		Possible co-payment please check Table of Cover
Mediastinum	5161	Tracheo-oesophageal fistula, repair of	No		
Mediastinum	5162	Repair, tracheo-oesophageal atresia	No		Possible co-payment please check Table of Cover

THORACIC SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Mediastinum	5163	Repair, tracheo-oesophageal fistula (TOF) alone (H-fistula)	No		Possible co-payment please check Table of Cover
Mediastinum	5164	Repair, tracheo-oesophageal fistula (TOF) and atresia, replacement	No		Possible co-payment please check Table of Cover
Mediastinum	5165	Oesophagectomy (all forms including three stages) (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Mediastinum	5171	Transection of oesophagus with repair, for oesophageal varices	No		Possible co-payment please check Table of Cover
Mediastinum	5172	Oesophageal devascularisation	No		Possible co-payment please check Table of Cover
Mediastinum	5801	Exploration of mediastinum	No	Diagnostic	Possible co-payment please check Table of Cover
Mediastinum	5802	Endoscopic extirpation of lesion of mediastinum	No	Diagnostic	Possible co-payment please check Table of Cover
Mediastinum	5863	Thymectomy, includes robotic approach	No		Possible co-payment please check Table of Cover
Mediastinum	5872	Excision of pericardium (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Mediastinum	5874	Pericardiocentesis	No		
Mediastinum	5876	Transthoracic drainage of pericardium	No		Possible co-payment please check Table of Cover
Mediastinum	5877	Creation of pericardial window or partial resection for drainage (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Mediastinum	5878	Closure of median sternotomy separation with or without debridement (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Other Cardiac/ Thoracic Surgeries	5804	Operation on lymphatic duct	No		Possible co-payment please check Table of Cover
Other Cardiac/ Thoracic Surgeries	5808	Transplantation of heart	No		Possible co-payment please check Table of Cover
Other Cardiac/ Thoracic Surgeries	5809	Correction of Tetralogy of Fallot	No		Possible co-payment please check Table of Cover
Other Cardiac/ Thoracic Surgeries	5813	Correction of total anomalous pulmonary venous connection	No		Possible co-payment please check Table of Cover
Other Cardiac/ Thoracic Surgeries	5822	Creation of valved cardiac conduit	No		Possible co-payment please check Table of Cover
Other Cardiac/ Thoracic Surgeries	5823	Creation of other cardiac conduit	No		Possible co-payment please check Table of Cover
Other Cardiac/ Thoracic Surgeries	5827	Excision of cardiac tumour	No		Possible co-payment please check Table of Cover
Other Cardiac/ Thoracic Surgeries	5828	Staged correction of hypoplastic left heart syndrome, per stage	No		Possible co-payment please check Table of Cover
Other Cardiac/ Thoracic Surgeries	5873	Decompression of cardiac tamponade (re. operation for bleeding)	No		Possible co-payment please check Table of Cover
Pacemaker	5141	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular	No		Possible co-payment please check Table of Cover

THORACIC SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Pacemaker	5142	Removal of single or dual chamber pacing cardioverter defibrillator electrode(s); by thoracotomy	No		Possible co-payment please check Table of Cover
Pacemaker	5223	Insertion of permanent pacemaker with epicardial electrode(s), by thoracotomy	No		Possible co-payment please check Table of Cover
Septum Procedures	5190	Rashkind septostomy	No		Possible co-payment please check Table of Cover
Septum Procedures	5814	Closure of defect of atrioventricular septum using dual prosthetic patches	No		Possible co-payment please check Table of Cover
Septum Procedures	5816	Closure of defect of interatrial septum	No		Possible co-payment please check Table of Cover
Septum Procedures	5817	Closure of defect of interventricular septum	No		Possible co-payment please check Table of Cover
Septum Procedures	5818	Planned repair of post infarction ventricular septal defect	No		Possible co-payment please check Table of Cover
Septum Procedures	5819	Emergency repair of post infarction ventricular septal defect	No		Possible co-payment please check Table of Cover
Septum Procedures	5821	Other open operations on the septum of the heart	No		Possible co-payment please check Table of Cover
Trachea	5919	Partial excision of trachea	No		Possible co-payment please check Table of Cover
Trachea	5920	Reconstruction of trachea	No		Possible co-payment please check Table of Cover
Trachea	5921	Tracheostomy, permanent	No		Possible co-payment please check Table of Cover For procedure codes 5921 and 5922, where these procedures are performed in an ICU setting, benefit is payable once only during the patient's stay in the intensive care unit
Trachea	5922	Insertion of mini tracheostomy	No		For procedure codes 5921 and 5922, where these procedures are performed in an ICU setting, benefit is payable once only during the patient's stay in the intensive care unit
Trachea	5923	Destruction of lesion of trachea by rigid endoscopy	No		
Trachea	5924	Dilatation of tracheal stricture by rigid endoscopy	No		
Valves	5151	Percutaneous trans septal mitral valvuloplasty (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Valves	5152	Valvuloplasty (other than mitral valvuloplasty)	No		Possible co-payment please check Table of Cover
Valves	5829	Replacement of mitral valve (includes valvuloplasty)	No		Possible co-payment please check Table of Cover
Valves	5832	Replacement of aortic valve (includes valvuloplasty)	No		Possible co-payment please check Table of Cover
Valves	5833	Replacement of tricuspid valve (includes valvuloplasty)	No		Possible co-payment please check Table of Cover
Valves	5834	Replacement of pulmonary valve (includes valvuloplasty/ valvotomy)	No		Possible co-payment please check Table of Cover
Valves	5837	Closed valvotomy	No		Possible co-payment please check Table of Cover
Valves	5839	Double valves	No		Possible co-payment please check Table of Cover
Valves	5841	Removal of obstruction from structure adjacent to valve of heart	No		Possible co-payment please check Table of Cover
Valves	5842	Triple valves	No		Possible co-payment please check Table of Cover
Valves	5855	Annuloplasty	No		Possible co-payment please check Table of Cover
Valves	5959	Revision of valve surgery	No		Possible co-payment please check Table of Cover

THORACIC SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Valves	333424	Percutaneous transcatheter mitral valve repair (leaflet coaptation), including fluoroscopy, angiography, transseptal puncture and echocardiography (TOE)	Yes		Possible co-payment please check Table of Cover For patients with mitral regurgitation for whom surgical mitral valve replacement is considered unsuitable (a) 5108 or 5008 is not payable in addition to this code 333424 (b) 5109 is not claimable when performed intraoperatively For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure 50% of the second highest valued procedure 25% of the third highest valued procedure
Ventricles	5854	Map guided surgery for ventricular arrhythmias	No		Possible co-payment please check Table of Cover
Ventricles	5857	Left ventricular aneurysmectomy	No		Possible co-payment please check Table of Cover
Ventricles	5859	Insertion, management and removal of ventricular assist device	No		Possible co-payment please check Table of Cover
Ventricles	5958	Revision closure of defect of intra ventricular septum	No		Possible co-payment please check Table of Cover
Vessels	5055	Aortic endarterectomy	No		Only for Irish Life Health approved brands of stimulators
Vessels	5075	Blalock operation	No		Possible co-payment please check Table of Cover
Vessels	5092	Venotomy and insertion of filter into the inferior vena cava (includes venogram)	No		Possible co-payment please check Table of Cover
Vessels	5118	Atherectomy	No		Possible co-payment please check Table of Cover
Vessels	5125	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement and coronary reconstruction	No		Possible co-payment please check Table of Cover
Vessels	5126	Transverse arch graft, with cardiopulmonary bypass	No		Possible co-payment please check Table of Cover
Vessels	5127	Descending thoracic aorta graft, open or endovascular, with or without bypass, with or without coverage of left subclavian artery origin, plus descending thoracic aortic origin extension(s), if required to level of coeliac origin	No		Possible co-payment please check Table of Cover
Vessels	5128	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	No		Possible co-payment please check Table of Cover
Vessels	5143	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass	No		Possible co-payment please check Table of Cover
Vessels	5144	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; with cardiopulmonary bypass	No		Possible co-payment please check Table of Cover
Vessels	5146	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension	No		Possible co-payment please check Table of Cover
Vessels	5147	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with coronary reconstruction	No		Possible co-payment please check Table of Cover
Vessels	5180	Pott's operation	No		Possible co-payment please check Table of Cover
Vessels	5219	Trans thoracic electro-cautery of subclavian lymph nodes	No		Possible co-payment please check Table of Cover
Vessels	5811	Atrial inversion for transposition of great vessels	No		Possible co-payment please check Table of Cover
Vessels	5812	Other correction of transposition of great vessels	No		Possible co-payment please check Table of Cover

THORACIC SURGERY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Vessels	5852	Correction of anomalous coronary arteries	No		Possible co-payment please check Table of Cover
Vessels	5861	Insertion, maintenance and removal of aortic counterpulsation balloon pump	No		Possible co-payment please check Table of Cover
Vessels	5870	Myocardial aneurysmectomy	No		Possible co-payment please check Table of Cover
Vessels	5871	Open correction of patent ductus arteriosus	No		Possible co-payment please check Table of Cover
Vessels	5879	Correction of truncus arteriosus	No		Possible co-payment please check Table of Cover
Vessels	5882	Closed correction of patent ductus arteriosus	No		Possible co-payment please check Table of Cover
Vessels	5883	Creation of shunt to pulmonary artery from aorta using interposition tube prosthesis	No		Possible co-payment please check Table of Cover
Vessels	5884	Pulmonary artery banding	No		Possible co-payment please check Table of Cover
Vessels	5886	Connection to pulmonary artery from aorta	No		Possible co-payment please check Table of Cover
Vessels	5887	Creation of shunt to pulmonary artery from subclavian artery using interposition tube prosthesis	No		Possible co-payment please check Table of Cover
Vessels	5888	Connection to pulmonary artery from subclavian artery	No		Possible co-payment please check Table of Cover
Vessels	5889	Repair of pulmonary artery/ PA De Banding	No		Possible co-payment please check Table of Cover
Vessels	5892	Pulmonary embolectomy	No		Possible co-payment please check Table of Cover
Vessels	5893	Open operations on pulmonary artery	No		Possible co-payment please check Table of Cover
Vessels	5957	Revision repair of coarctation of aorta	No		Possible co-payment please check Table of Cover

UROLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Biopsy	688	Biopsy of penis (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Biopsy	713	Biopsy of prostate (perineal or transrectal) includes ultrasound guidance (I.P.)	No	Independent Procedure, Diagnostic, Side Room	
Biopsy	740	Testicular biopsy (needle) (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Biopsy	741	Testicular biopsy (open surgical) (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Biopsy	955	Renal biopsy (needle)	No	Diagnostic	
Bladder	836	Bladder, instillation of anticarcinogenic agent (Mitomycin C)	No	Side Room	
Bladder	839	Bladder, instillation of therapeutic agent for interstitial cystitis	No	Side Room	
Bladder	843	Bladder, instillation of anticarcinogenic agent (BCG medac)	No	Side Room	

UROLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Bladder	846	Botulinum toxin injection to bladder wall only for idiopathic or neurogenic detrusor over activity in patients who have not responded to conservative treatments (maximum of one injection payable per 9 month period since the last injection)(I.P.)	No	Independent Procedure, Day Care	
Bladder	850	Bladder neck, transurethral resection of	No		
Bladder	855	Primary transurethral resection of bladder tumour(s), one or more (for diathermy of, use 885)	No		
Bladder	865	Cystectomy, partial	No		
Bladder	875	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis	No		
Bladder	877	Cystectomy, complete, with continent diversion, any technique, using any segment of small and/ or large bowel to construct neobladder	No		
Bladder	878	Appendico-vesicostomy (Mitrofanoff procedure)	No		
Bladder	879	Cutaneous vesicostomy (I.P.)	No	Independent Procedure	
Bladder	881	Cystoscopy with removal of JJ stent	No	Day Care	
Bladder	882	Cystoscopy, with or without biopsy, including stress testing for female stress urinary incontinence or male post prostatectomy incontinence (I.P.)	No	Independent Procedure, Day Care	
Bladder	883	Cystoscopy with or without biopsy, with prostatic biopsy (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Bladder	884	Cystoscopy with or without biopsy (I.P.)	No	Independent Procedure, Diagnostic, Day Care, Monitored Anaesthesia Care	
Bladder	885	Cystoscopy with diathermy to bladder tumour(s) (I.P.)	No	Independent Procedure, Day Care	
Bladder	887	Cystoscopy with insertion of JJ stent	No		
Bladder	888	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	No		
Bladder	889	Cystourethroscopy with resection or fulguration of ectopic ureterocele(s) unilateral or bilateral in paediatric cases	No		
Bladder	890	Cystoscopy with ureteric catheterisation (I.P.)	No	Independent Procedure, Diagnostic, Day Care	
Bladder	891	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (e.g. balloon dilation, laser, electrocautery and incision)	No		
Bladder	892	Cystoscopy with insertion of thermo-expandable metallic stent for relief of chronic ureteric stricture only	No		
Bladder	895	Cystoscopy with ureteroscopy and removal of ureteric calculus (I.P.)	No	Independent Procedure	
Bladder	897	Cystolithotomy	No		

UROLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Bladder	898	Percutaneous suprapubic cystostomy (I.P.)	No	Independent Procedure, Side Room, Local Anaesthetic	
Bladder	899	Substitution cystoplasty	No		
Bladder	901	Closure of ruptured bladder (intraperitoneal)	No		
Bladder	906	Augmentation cystoplasty	No		
Bladder	907	Bladder neck, transurethral incision of	No		
Bladder	908	Excision of ureterocele in children including reconstruction and repair of sphincters including reimplantation of ureters	No		
Bladder	910	Excision of bladder diverticulum	No		
Bladder	924	Litholapaxy	No		1 Night Only
Bladder	960	Open suprapubic cystostomy (I.P.)	No	Independent Procedure	
Bladder	4645	Closure of bladder exstrophy	No		
Bladder	4691	Young-Dees operation	No		
Bladder	5056	Insertion of neurostimulator pulse generator and electrodes: sacral nerve for bladder muscle control: trial stage (I.P.)	Yes	Independent Procedure, Day Care	(a) Treatment of urge urinary incontinence or symptoms or urge-frequency when all of the following criteria are met: (i) The member has experienced urge urinary incontinence or symptoms of urge frequency for at least 12 months and the condition has resulted in significant disability (the frequency and/ or severity of symptoms limits the members ability to participate in activities of daily living) and (ii) Pharmacotherapies (i.e. at least 2 different anti-cholinergic drugs or a combination of this and a tricyclic depressant) as well as behavioural treatments (e.g. pelvic floor exercises, bio feedback and fluid management) and related activities have failed (b) Treatment of non-obstructive urinary retention when all of the following criteria are met: (i) The member has experienced urinary retention for at least 12 months and the condition has resulted in significant disability (this frequency and/ or severity of symptoms are limiting the members ability to participate in activities of daily living) and (ii) Pharmacotherapies (e.g. beta blockers and cholinergics, anti biotics for urinary tract infections) as well as intermittent catheterisation have failed or are not well tolerated
Bladder	5057	Insertion of neurostimulator pulse generator and electrodes: sacral nerve for bladder muscle control: permanent implantation (I.P.)	Yes	Independent Procedure	1 Night Only Conditions of payment for procedure code 5057 are as follows: (a) Treatment of urge incontinence or symptoms of urge frequency provided test stimulation of the patient satisfies the criteria indicating at least 50% decrease in symptoms (b) Treatment of non-obstructive urinary retention provided test stimulation of the patient satisfies the criteria indicating at least 50% decrease in residual urinary volume
Bladder	5845	Ileal conduit and bowel anastomosis	No		
Dialysis	822	Creation of permanent shunt for haemodialysis access, involving dissection of vessel/ tunnelling, insertion of graft, suturing to vein and artery	No		
Dialysis	834	Insertion of tunnelled intraperitoneal catheter for dialysis, permanent	No		Refer to procedure 838 for the removal of permanent intraperitoneal cannula catheter for drainage for dialysis (not for the removal of Hickman, Broviac, Vascath, or similar)
Dialysis	838	Removal of tunnelled intraperitoneal catheter	No		
Dialysis	841	Removal of permanent shunt for haemodialysis access (not for the removal of dialysis catheter)	No	Day Care	

UROLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Genitalia	645	Epididymectomy, unilateral (I.P.)	No	Independent Procedure, Day Care	
Genitalia	655	Hydrocelectomy, bilateral (I.P.)	No	Independent Procedure	1 Night Only
Genitalia	660	Hydrocelectomy, unilateral (I.P.)	No	Independent Procedure	1 Night Only
Genitalia	669	Orchidectomy, radical, for cancer, inguinal approach	No		
Genitalia	670	Orchidectomy, bilateral (I.P.)	No	Independent Procedure	
Genitalia	672	Drainage of intra-scrotal abscess (I.P.)	No	Independent Procedure	
Genitalia	673	Orchidectomy, radical, for cancer, inguinal approach including artificial prosthesis	No		
Genitalia	674	Orchidectomy, radical, for cancer, with abdominal exploration	No		
Genitalia	675	Orchidectomy, unilateral (I.P.)	No	Independent Procedure	
Genitalia	679	Orchidectomy, radical, for cancer, with abdominal exploration including artificial prosthesis	No		
Genitalia	682	Adult circumcision (I.P.)	No	Independent Procedure, Day Care	For patients 16 years and older
Genitalia	683	Paediatric circumcision (I.P.)	No	Independent Procedure, Day Care	For patients aged below 16 years
Genitalia	685	Penis, amputation of, partial	No		
Genitalia	687	Penis, amputation of, total	No		
Genitalia	692	Excision of penile plaque with or without graft	No		
Genitalia	693	Nesbit procedure (plastic operation on penis to correct angulation)	No		
Genitalia	694	Removal of penile prosthesis	No		
Genitalia	695	Prepuce, dorsal incision of	No	Day Care	
Genitalia	696	Release of priapism (needle drainage)	No		
Genitalia	697	Excision of epididymal cyst(s), unilateral (I.P.)	No	Independent Procedure, Day Care	
Genitalia	698	Excision of epididymal cyst(s), bilateral (I.P.)	No	Independent Procedure, Day Care	
Genitalia	699	Epididymectomy, bilateral (I.P.)	No	Independent Procedure	
Genitalia	704	Epididymovasostomy, bilateral	No		
Genitalia	714	Laparoscopy, orchidopexy for intra-abdominal testis	No	Day Care	
Genitalia	715	Orchidopexy, inguinal approach with or without hernia repair, unilateral (I.P.)	No	Independent Procedure, Day Care	
Genitalia	720	Orchidopexy, inguinal approach with or without hernia repair, bilateral (I.P.)	No	Independent Procedure, Day Care	

UROLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Genitalia	735	Orchidopexy, unilateral for torsion with exploration and/ or fixation of opposite side	No		
Genitalia	736	Orchidopexy, abdominal approach for intra-abdominal testis	No	Day Care	
Genitalia	742	Testicular prosthesis, insertion/ replacement/ removal of, unilateral	No	Day Care	
Genitalia	743	Testicular prosthesis, insertion/ replacement/ removal of, bilateral	No		
Genitalia	755	Varicocelectomy	No	Day Care	
Genitalia	992	Pubovaginal sling urethropexy with tension-free vaginal tape (TVT)	No		1 Night Only
Genitalia	993	Vesico colic fistula, excision of, and sigmoid colectomy	No		
Genitalia	994	Pubovaginal sling with cystocele repair or rectocele repair	No		
Genitalia	997	Pubovaginal sling including cystocele and rectocele repair	No		
Genitalia	4681	Insertion of malleable penile prosthesis	No		The use of such implants is limited to consultant Urologists with supported specialised knowledge, skill and expertise/ training in this area and who perform at 30 of these cases annually in any given hospital The clinical conditions considered appropriate for the use of such prosthesis are: (a) Post radical prostatectomy (b) Post cystectomy (c) Post major colonic/ colorectal surgery (d) Post radiotherapy/ cancer treatment to penis/ prostate (e) For persons suffering from confirmed prolonged Type 1 or type 2 diabetes which causes erectile dysfunction due to diabetic related complications, urethral injury, pelvic fracture causing urethral injury which leads to long term erectile dysfunction Clinical indicators: (i) This is a 3rd line therapy following at least 3 years of erectile dysfunction following failure of oral medication prescribed by a consultant Urologist and/ or consultant Psychiatrist and following failure (where appropriate) of the use of inter-cavernous injections and use of vacuum pump devices (ii) Patients will also have undergone a prolonged course of psychological and psychotherapy evaluation and advice and/ or including medication (iii) The life expectancy of the above prosthesis will be expected to be a minimum of 15 years (subject to any clinical reasons e.g. infection)
Genitalia	4682	Insertion of inflatable penile prosthesis	No		The use of such implants is limited to consultant Urologists with supported specialised knowledge, skill and expertise/ training in this area and who perform at 30 of these cases annually in any given hospital The clinical conditions considered appropriate for the use of such prosthesis are: (a) Post radical prostatectomy (b) Post cystectomy (c) Post major colonic/ colorectal surgery (d) Post radiotherapy/ cancer treatment to penis/ prostate (e) For persons suffering from confirmed prolonged Type 1 or type 2 diabetes which causes erectile dysfunction due to diabetic related complications, urethral injury, pelvic fracture causing urethral injury which leads to long term erectile dysfunction Clinical indicators: (i) This is a 3rd line therapy following at least 3 years of erectile dysfunction following failure of oral medication prescribed by a consultant Urologist and/ or consultant Psychiatrist and following failure (where appropriate) of the use of inter-cavernous injections and use of vacuum pump devices (ii) Patients will also have undergone a prolonged course of psychological and psychotherapy evaluation and advice and/ or including medication (iii) The life expectancy of the above prosthesis will be expected to be a minimum of 15 years (subject to any clinical reasons e.g. infection)
Kidney	915	Embolisation of haemangioma of kidney	No		

UROLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Kidney	916	Laparoscopy, partial nephrectomy, includes robotic approach	No		
Kidney	917	Laparoscopy, radical nephrectomy	No		
Kidney	918	Laparoscopy, surgical, nephrectomy, with total ureterectomy	No		
Kidney	919	Laparoscopy, surgical, nephrectomy, including partial ureterectomy	No		
Kidney	920	Nephrectomy, partial	No		
Kidney	921	Radical nephrectomy (includes adrenalectomy and para-aortic lymph nodes)	No		
Kidney	922	Radical nephrectomy including caval extension above and/ or below liver	No		
Kidney	923	Kidney transplant	No		
Kidney	925	Simple nephrectomy	No		
Kidney	930	Nephrolithotomy	No		
Kidney	931	Percutaneous nephrolithotomy, with or without guidance	No		
Kidney	933	Percutaneous nephrolithotomy stag-horn calculus, with or without guidance	No		
Kidney	934	Percutaneous nephrostomy with or without antegrade pyelogram or stent placement	No		
Kidney	936	Percutaneous tract formation for renal stone removal by another consultant (I.P.)	No	Independent Procedure	
Kidney	937	Living donor nephrectomy	No		
Kidney	938	Nephrectomy with total ureterectomy and bladder cuff, through same incision	No		
Kidney	939	Nephrectomy with total ureterectomy and bladder cuff, through separate incisions	No		
Kidney	940	Pyelolithotomy	No		
Kidney	941	Percutaneous nephrolithotomy, pelvic or calyceal involving contact lithotripsy, with or without guidance	No		
Kidney	945	Pyeloplasty	No		
Kidney	946	Pyeloplasty, complicated (congenital kidney abnormality secondary pyeloplasty, solitary kidney, calycoplasty) neonate up to one year of age	No		
Kidney	947	Radical nephrectomy in children (e.g. Wilms tumour) with contralateral exploration	No		
Kidney	948	Laparoscopy, surgical; pyeloplasty	No		
Kidney	956	Renal cyst puncture and aspiration	No		
Kidney	5911	Ureteroscopy & contact lithotripsy with placement/ removal of J stent, one or more sessions per hospital stay (I.P.)	No	Independent Procedure	
Kidney	59101	Extracorporeal shock wave lithotripsy (ESWL) - as directed by a consultant Urologist for urinary tract stone(s), who has interpreted the relevant radiological tests/ scans and is present as the commencement and cessation of the session of therapy	No		For procedure code 59101, 59102 where monitored anaesthesia is required, claims must be supported by a medical report from the consultant Anaesthetist outlining the necessity for monitored anaesthesia

UROLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Kidney	59102	Extracorporeal shock wave lithotripsy (ESWL) - as directed and prescribed by a consultant Urologist for urinary tract stone(s), who has interpreted the relevant radiological tests/ scans and where the consultant is not present for the duration of the treatment	No		For procedure code 59101, 59102 where monitored anaesthesia is required, claims must be supported by a medical report from the consultant Anaesthetist outlining the necessity for monitored anaesthesia
Kidney	59103	Intra renal flexible ureterorenoscopy for intra renal stones	No	Day Care	
Prostate	700	Transurethral prostatectomy	No		
Prostate	701	Radical retropubic nerve sparing prostatectomy (includes bilateral pelvic lymph adenectomy with bladder neck reconstruction and anastomosis to the urethra)	No		
Prostate	707	Laser (Green Light) vaporisation of prostate including control of post operative bleeding, complete (meatotomy, cystourethroscopy, urethral calibration and/ or dilation, internal uretherotomy and transurethral resection of prostate are included if performed)	No		1 Night Only
Prostate	708	Open prostatectomy	No		
Prostate	709	Laparoscopic surgical prostatectomy, retropubic radical, including nerve sparing (includes robotic assisted prostatectomy with the Da Vinci Prostatectomy Radical system)	No		
Prostate	716	Laser enucleation of the prostate with morcellation including control of postoperative bleeding, complete (meatotomy, cystourethroscopy, urethral calibration and/ or dilation, internal uretherotomy and transurethral resection of prostate are included if performed)	No		1 Night Only
Prostate	904091	Urolift implant treatment known as prostatic urethral lift (PUL) for benign prostatic hypertrophy (BPH) to a maximum of 5 pins	No	Once every 5 years maximum	
Ureter	975	Open ureterolithotomy	No		
Ureter	981	Ureterolysis, unilateral, by laparotomy approach (I.P.)	No	Independent Procedure	
Ureter	982	Ureterolysis, bilateral, by laparotomy approach (I.P.)	No	Independent Procedure	
Ureter	983	Ureteric reimplantation, unilateral for reflux, stricture or fistula (I.P.)	No	Independent Procedure	
Ureter	984	STING procedure (initial) for vesicoureteric reflux (initial) (I.P.)	No	Independent Procedure, Day Care	
Ureter	986	Ureteric reimplantation, bilateral for reflux, stricture or fistula (I.P.)	No	Independent Procedure	
Ureter	987	STING procedure for vesicoureteric reflux (repeat)	No	Day Care	
Ureter	989	Sling operation for the correction of male incontinence, with synthetic implant (I.P.)	No	Independent Procedure	1 Night Only
Ureter	995	Ureterostomy, unilateral	No		
Ureter	996	Ureteric substitution (with bowel segment)	No		
Ureter	998	Sling operation for the correction of male incontinence, without implant (I.P.)	No	Independent Procedure	1 Night Only Benefit payable for patients who are 6 months post-prostatectomy, who have had no improvement in the severity of urinary incontinence despite trials of behavioural and pharmacological therapies
Ureter	1000	Ureterostomy, bilateral	No		

UROLOGY

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Urethra	664	Meatoplasty (for meatotomy use code 665) (I.P.)	No	Independent Procedure, Day Care	
Urethra	665	Meatotomy (I.P.)	No	Independent Procedure, Day Care	
Urethra	666	Urethroplasty for penile or bulbar urethral stricture	No		
Urethra	667	Acute repair of rupture of membranous urethra	No		
Urethra	668	Urethroplasty for repair of prostatic or membranous urethral stricture, complete procedure	No		
Urethra	676	Removal of implanted inflatable urethral/ bladder neck sphincter, including pump, reservoir and cuff (AUS)	No		
Urethra	677	Hypospadias, meatal advancement and glanduloplasty (MAGPI) procedure	No	Day Care	
Urethra	703	Insertion of an endo urethral stent for urethral stricture	No	Day Care	
Urethra	973	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	No	Diagnostic	1 Night Only
Urethra	974	Cystourethroscopy, with ureteroscopy and/ or pyeloscopy; with resection of urethral or renal pelvic tumour	No		
Urethra	1015	Urethral dilatation (I.P.)	No	Independent Procedure, Side Room	
Urethra	1030	Optical urethrotomy (I.P.)	No	Independent Procedure	1 Night Only
Urethra	1032	Implantation of inflatable urethral/ bladder neck sphincter, including placement of pump, reservoir and cuff (AUS)	No		
Urethra	4660	Epispadias, reconstruction of urethra	No		
Urethra	4670	Hypospadias, fistula closure	No		
Urethra	4675	Hypospadias, reconstruction of urethra	No		
Urethra	4676	One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/ or island flap	No		
Urethra	571512	Pubovaginal sling urethropexy with autologous or allogenic fascia	No		

VASCULAR

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Anastomosis	820	Arteriovenous anastomosis in arm	No		
Anastomosis	1453	Arteriovenous anastomosis, open by basilic vein transposition	No		Possible co-payment please check Table of Cover
Anastomosis	1465	Splenorenal anastomosis	No		Possible co-payment please check Table of Cover
Aneurysms	1401	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta	No		Possible co-payment please check Table of Cover

VASCULAR

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Aneurysms	1402	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, coeliac, renal)	No		Possible co-payment please check Table of Cover
Aneurysms	1403	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric external)	No		Possible co-payment please check Table of Cover
Aneurysms	1404	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, using aorto-aortic tube prosthesis	No		Possible co-payment please check Table of Cover
Aneurysms	1409	Aorta bi-iliac bypass for atherosclerosis or aneurysm; endovascular (using prosthesis) (I.P.)	No	Independent Procedure	
Aneurysms	1416	Thrombin injection into groin for pseudoaneurysm (including ultrasound guidance)	No		
Aneurysms	1427	Supra-renal aneurysm repair	No		Possible co-payment please check Table of Cover
Aneurysms	1428	Repair of supra-renal aortic aneurysm rupture	No		Possible co-payment please check Table of Cover
Aneurysms	1436	Repair of ruptured iliac artery aneurysm	No		Possible co-payment please check Table of Cover
Aneurysms	1461	Repair of subclavian aneurysm	No		Possible co-payment please check Table of Cover
Aneurysms	1474	Repair of femoral artery aneurysm	No		Possible co-payment please check Table of Cover
Bypass Procedures	1432	Aorto bi-iliac bypass for atherosclerosis or aneurysm (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Bypass Procedures	1433	Aorto-femoral or bifemoral bypass for atherosclerosis or aneurysm (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Bypass Procedures	1443	Obturator bypass from aorta or iliac to profunda or distal femoral bypass	No		Possible co-payment please check Table of Cover
Bypass Procedures	1446	Aortic exclusion by axillo-femoral bypass	No		Possible co-payment please check Table of Cover
Bypass Procedures	1449	Vertebral artery bypass or repair	No		Possible co-payment please check Table of Cover
Bypass Procedures	1456	Carotid subclavian bypass	No		Possible co-payment please check Table of Cover
Bypass Procedures	1457	Subclavian subclavian bypass	No		Possible co-payment please check Table of Cover
Bypass Procedures	1459	Subclavian to branchial bypass or endarterectomy	No		Possible co-payment please check Table of Cover
Bypass Procedures	1463	Repair or bypass of brachial to radial or ulnar vessel, any method including harvesting of graft material	No		Possible co-payment please check Table of Cover
Bypass Procedures	1467	Femoral to popliteal bypass, above knee vein	No		Possible co-payment please check Table of Cover
Bypass Procedures	1468	Femoral to popliteal bypass, above knee synthetic	No		Possible co-payment please check Table of Cover
Bypass Procedures	1469	Femoral to popliteal bypass, below knee vein	No		Possible co-payment please check Table of Cover
Bypass Procedures	1471	Femoral to popliteal bypass, below knee synthetic	No		Possible co-payment please check Table of Cover
Bypass Procedures	1478	Femoral tibial artery bypass, including tibial-peroneal and peroneal artery bypass, or other distal vessels	No		Possible co-payment please check Table of Cover
Bypass Procedures	1479	Popliteal aneurysm artery repair or bypass	No		Possible co-payment please check Table of Cover
Bypass Procedures	1481	Femorofemoral bypass	No		Possible co-payment please check Table of Cover

VASCULAR

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Consultation	647012	Co-surgery benefit for vascular surgeon who assists in ALIF spinal surgery (I.P.)	Yes	Independent procedure	Claimable by vascular surgeon assisting in ALIF spinal surgery procedure
Embolus/ Thrombus	1280	Common femoral artery embolectomy	No		Possible co-payment please check Table of Cover
Embolus/ Thrombus	1306	Transcatheter embolisation, extremity, arteriovenous malformation (AVM) (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Embolus/ Thrombus	1307	Transcatheter removal of intravascular thrombus or foreign body	No		Possible co-payment please check Table of Cover
Embolus/ Thrombus	1308	Transcatheter therapy, infusion for thrombolysis other than coronary, including necessary local anaesthesia, all lesser order selective catheterisation used in the approach and any necessary pre and post-injection care	No	Side Room	
Embolus/ Thrombus	1430	Iliac or femoral veins - removal of thrombus	No		
Embolus/ Thrombus	1437	Endarterectomy of iliac vessels alone	No		Possible co-payment please check Table of Cover
Embolus/ Thrombus	1439	Renal artery anastomosis, endarterectomy or re-implantation or bypass	No		Possible co-payment please check Table of Cover
Embolus/ Thrombus	1441	Embolectomy of visceral branches, superior mesenteric or renal arteries	No		Possible co-payment please check Table of Cover
Embolus/ Thrombus	1447	Endarterectomy of internal/ external common carotid artery with or without patch graft, with or without shunt	No		Possible co-payment please check Table of Cover
Embolus/ Thrombus	1462	Brachial embolectomy	No		Possible co-payment please check Table of Cover
Embolus/ Thrombus	1476	Popliteal artery embolectomy	No		Possible co-payment please check Table of Cover
Embolus/ Thrombus	1477	Tibial artery embolectomy	No		Possible co-payment please check Table of Cover
Endarterectomy	1434	Endarterectomy of abdominal aorta and iliac vessels	No		Possible co-payment please check Table of Cover
Endarterectomy	1472	Profundaplasty with or without patch or endarterectomy	No		Possible co-payment please check Table of Cover
Endarterectomy	1473	Common femoral artery endarterectomy	No		Possible co-payment please check Table of Cover
Endovascular	1419	Transluminal dilation of iliac vessels with or without stent or graft	No		Possible co-payment please check Table of Cover
Endovascular	1421	Transluminal dilation with or without stent of carotid vessels	No		Possible co-payment please check Table of Cover
Endovascular	1422	Transluminal dilation with or without stent or graft of femoral vessels	No		Possible co-payment please check Table of Cover
Endovascular	1423	Transluminal dilation with stent of distal vessels	No		Possible co-payment please check Table of Cover
Endovascular	1424	Transluminal dilation of distal vessels	No		Possible co-payment please check Table of Cover
Other Vascular Procedures	1250	Arterial biopsy (temporal artery, biopsy, bilateral under local anaesthetic)	No	Diagnostic, Side Room	
Other Vascular Procedures	1290	Ligation of major vessels	No		Possible co-payment please check Table of Cover
Other Vascular Procedures	1305	Renal stenosis, repair of	No		Possible co-payment please check Table of Cover

VASCULAR

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Other Vascular Procedures	1442	Removal of infected aortic prosthesis	No		Possible co-payment please check Table of Cover
Other Vascular Procedures	1450	Portosystemic shunt	No		Possible co-payment please check Table of Cover
Other Vascular Procedures	1452	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis; autogenous or non-autogenous graft	No		Possible co-payment please check Table of Cover
Other Vascular Procedures	1454	Translocation of common carotid to subclavian artery	No		Possible co-payment please check Table of Cover
Other Vascular Procedures	1466	Reoperation, femoral-popliteal or femoral (popliteal)-anterior tibial, posterior tibial, peroneal artery or other distal vessels (payable in full with code for main procedure)	No		Payable in full with code for main procedure
Varicose Veins	1408	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed (I.P.)	No	Independent Procedure, Day Care	
Varicose Veins	1411	Endovenous radiofrequency ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; one leg	No	Day Care	
Varicose Veins	1412	Endovenous radiofrequency ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; both legs	No	Day Care	
Varicose Veins	1413	Endovenous laser ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; one leg	No	Day Care	The treatment of spider/ thread veins and telangiectasia are specifically excluded from benefit
Varicose Veins	1414	Endovenous laser ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; both legs	No	Day Care	The treatment of spider/ thread veins and telangiectasia are specifically excluded from benefit
Varicose Veins	1435	Inferior vena cava ligation/ clipping, with or without thrombus	No		Possible co-payment please check Table of Cover
Varicose Veins	1490	Varicose veins, exploration and removal of thrombus, unilateral	No		
Varicose Veins	1493	Flush ligation of long saphenous vein at sapheno-femoral junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in one leg	No	Day Care	
Varicose Veins	1494	Flush ligation of long saphenous vein at sapheno-femoral junction in both groins with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in both legs	No	Day Care	
Varicose Veins	1495	Varicose veins, exploration and removal of thrombus, bilateral	No		
Varicose Veins	1496	Flush ligation of long saphenous vein at sapheno-femoral junction in the groin with or without complete stripping plus ligation of the short saphenous vein at the sapheno-popliteal junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in one leg	No	Day Care	Documentation must be provided in order to support incompetence of the short saphenous vein – the Doppler scan report must therefore be attached to the claim form
Varicose Veins	1497	Flush ligation of long saphenous vein at sapheno-femoral junction in the groin with or without complete stripping plus ligation of the short saphenous vein at the sapheno-popliteal junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in both legs	No	Day Care	Documentation must be provided in order to support incompetence of the short saphenous vein – the Doppler scan report must therefore be attached to the claim form
Varicose Veins	1498	Flush ligation of long saphenous vein at sapheno-femoral junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in the other leg	No	Day Care	
Varicose Veins	1499	Flush ligation of short saphenous vein at sapheno-popliteal junction behind the knee with or without complete stripping; multiple incisions in calf with avulsion and ligation of varicose veins; one leg	No	Day Care	

VASCULAR

SUB-SPECIALITY	CODE	DESCRIPTION	PRE-APPROVAL	PAYMENT INDICATORS	PAYMENT RULES
Varicose Veins	1501	Flush ligation of short saphenous veins at sapheno-popliteal junctions behind both knees with or without complete stripping; multiple incisions in both calves with avulsion and ligation of varicose veins in both legs	No		1 Night Only
Varicose Veins	1502	Ligation of single varicose vein in thigh or calf (I.P.)	No	Independent Procedure, Side Room	
Varicose Veins	1503	Ligation of multiple varicose veins one or both legs (I.P.)	No	Independent Procedure, Day Care	
Varicose Veins	1526	Stab avulsion of varicose vein(s), one leg (I.P.)	No	Independent Procedure, Side Room	
Varicose Veins	1527	Stab avulsion of varicose vein(s), both legs (I.P.)	No	Independent Procedure, Side Room	
Vessel Repair	1429	Tube graft repair of abdominal aorta	No		Possible co-payment please check Table of Cover
Vessel Repair	1431	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; with or without the involvement of other vessels; for other vessels not specified in the above codes (I.P.)	No	Independent Procedure	Possible co-payment please check Table of Cover
Vessel Repair	1438	Visceral artery repair, re-anastomosis or endarterectomy	No		Possible co-payment please check Table of Cover
Vessel Repair	1444	Repair of abdominal aortic trauma	No		Possible co-payment please check Table of Cover
Vessel Repair	1451	Open repair of subclavian artery	No		Possible co-payment please check Table of Cover
Vessel Repair	1458	Thoracotomy with repair of vessels of arch of aorta	No		Possible co-payment please check Table of Cover
Vessel Repair	1464	Repair of trauma to brachial artery with endarterectomy patch or bypass	No		Possible co-payment please check Table of Cover
Vessel Repair	1482	Repair of femoral or popliteal vessels due to trauma	No		Possible co-payment please check Table of Cover