Schedule of Benefits for Professional Fees

Aviva Health Insurance Ireland Limited
2013/2014

AVIVA
Looking out for you

Contents

RULES

RATES

SCHEDULE OF BENEFITS FOR PROFESSIONAL FEES FROM AVIVA HEALTH INSURANCE IRELAND LIMITED

Welcome to Aviva's schedule of benefits.

This book displays the professional fees for all medical, surgical and diagnostic procedures and tests covered by health insurance from Aviva, for inpatient and day case as set out in the rules of Aviva Health Insurance Ireland.

To improve both your efficient payment and the member's experience, can you please provide your patient with the name and code of the procedure (where possible) to enable your patient to establish the level of cover their plan provides for the particular procedure from the Aviva customer care agent.

For further information or queries; please contact us:
By telephone at **1850 718 718**
By email us on **provider.support@avivahealth.ie**
Our dedicated provider website **www.avivahealth.ie/medical-providers**
In writing to **PO Box 764 , Togher, Cork**

Thank you,

Colm O'Sullivan
Provider Affairs
Aviva Health Insurance Ireland Limited

GENERAL GROUND RULES

1. This Schedule of Benefits for Professional Fees outlines the professional fee services and benefits available from Aviva to *Consultants who are registered with Aviva for the treatment of private patients for medically necessary procedures in an Aviva approved hospital or treatment centre. Benefits listed in the Schedule apply to admissions on or after 1st October 2013 for the period of the agreement up to 31st August 2014.

2. Medically necessary means treatment or a hospital stay as defined in the Aviva member's handbook. This means that any treatment or diagnostic investigation will be provided solely for medical necessity, in accordance with best medical standards of practice, will be consistent with the symptoms or diagnosis of treatment. The treatment / diagnostic investigation will be performed in the most appropriate medical setting.

   Thus this medical necessity for In–Patient, Day Care and Side Room procedures/treatments will not extend to those services which are appropriate to outpatient settings in the view of Aviva and its medical advisory board, based on international standards and / or practice. Thus with the exception of designated Day Care and Side Room procedures, Consultant and hospital benefit ***is not*** provided for patients requiring investigation only such as radiology, pathology, or MRI scans unless they also require the intensity of service that would justify an in-patient admission.

3. The professional fee benefits apply to listed In–Patient, Day Care and Day Care Side Room procedures/treatments where these services are listed in this Schedule and where a service is provided to a patient in an Aviva approved facility, in an Aviva approved hospital or treatment centre listed in the Aviva Directory of Hospitals.

4. The professional fee benefits apply to procedures/treatments where that specific service can be provided in an Aviva approved hospital or treatment centre listed in the Aviva Directory of Hospitals and where the Aviva has agreed to reimburse the professional fee and hospital charges.

5. Approved hospitals and treatment centres are those facilities that Aviva recognise for the purpose of providing treatment to Aviva members where the specific technology and services approved and subject to the Rules, Terms and Conditions of Membership that apply to the patient's health insurance contract and level of cover with us at the time of treatment.

6. In the case of a Public Consultant post, the professional fee benefits apply where the Consultant holds the relevant Consultant payment category contract enabling him or her to charge for their professional services i.e. the payment category contract which the Consultant holds with the Health Service Executive, by virtue of the Buckley or 2008 Consultant Contract criteria, or any successor category.

7. The values recorded in this Schedule as Participating Benefits are payable to Consultants who have agreed to participate in the Full Cover Scheme.

8. The values recorded in this Schedule as Standard Benefits are payable to Consultants who have not agreed to participate in the Full Cover Scheme

9. On a certain date/dates each month Aviva will pay to Consultants the due value of properly collated invoices, which have been assessed to be eligible for payment and where our Claims Department have received the appropriate completed claim form and any other medical information which they deem necessary in order to assess the claim.

10. The benefit payable for a procedure or medical service is subject to the Ground Rules within the section where the service is listed.

11. A full description of the actual service(s), treatment(s) and procedure(s) including the date(s) of service(s), provided to a private patient should be documented on the appropriate claim form. It is not possible for us to assess a claim based on the procedure code(s).

    A comprehensive description of the actual service(s) and/or procedure(s) will ensure the correct assessment of benefit for fees submitted. You may include supplementary reports with the claim form if necessary. This will greatly assist Aviva in the assessment of claims and eliminate the need for supplementary enquiries if a comprehensive report is provided on the claim form.

12. Investigations which include pathology and radiology, performed prior to admission to hospital (in-patient, day care or side room) e.g. in an Emergency Department or on a pre- admission basis consultation cannot be included as part of the claim for any subsequent hospital admission. As a consequence the date of each individual test is required in order that we can eliminate the possibility that a test was performed pre or post admission. Such expenses may be included for assessment as part of the patient's Out-Patient Scheme.

13. Consultants cannot claim for a different procedure or medical service in lieu of the actual procedure or service given to the patient.

14. In the event of a previously rejected claim becoming subsequently payable on the production of new information, the participating Consultants will agree to accept the participating rates of benefit for the services rendered to the patient.

15. All Consultant benefits listed in this Schedule are only payable when the Consultant admits the patient to the hospital in which he or she has admitting rights and where these admission rights have been accepted as valid by Aviva for that specific Consultant.

16. The procedures and services is only payable when ***personally*** provided by the Consultant to the patient.

17. The procedures and services are payable subject to any conditions of payment indicators and ground rules shown in this Schedule.

18. Benefit is ***not payable*** to a Consultant for supervision of another doctor who performs the procedure or medical service.

19. Aviva will not pay fees for procedures that are regarded as experimental, or a clinical trial, unless agreed in advance with Aviva.

20. All new procedures and medical services should be notified to Aviva and will be evaluated in consultation with Aviva's Medical Advisors. Following evaluation where Aviva do not agree to include the procedure or medical service and a Consultant carries out such a procedure or service the Consultant must give advance notice to the patient that the costs involved will not be payable by Aviva. Any charges made are, therefore, a matter between the patient and the consultant.

21. A separate fee is not payable for the completion of claim forms or any other medical report.

22. The basis for claiming professional fee benefits is the completed Aviva claim form, by the admitting Consultant Surgeon/Physician together with an individual account (bill) in respect of the services provided to each patient. Accounts must include the Consultants:

    - Name
    - Aviva doctor code
    - PPS number
    - Reference/invoice number
    - Patient's name and address
    - Aviva surgical procedure code
    - Date of service
    - Agreed rate for service

    Where appropriate the following additional information must be supplied on the account:
    - Medical attendance – start and end date
    - Consultations – to date and specify whether major or ordinary (in the case of a major consultation the duration must be specified)
    - Radiology and Pathology – date of service, unit charge, number done and total amount billed
    - Anaesthesia – specify whether general, regional or monitored anaesthesia
    - Transfer of care – specify date of transfer and number of days billed for
    - Intensive care medical benefit – specify number of days in ICU as well as the appropriate charge

23. For hospitals which operate through the Aviva direct settlement of hospital and associated consultant professional fee charges, the claiming of Pathologist or Radiologist benefit will continue on the basis of a fully completed and collated Aviva claim form as completed by the admitting consultant surgeon/physician, which will be submitted by the hospital in conjunction with its own invoice for services provided. However, in **exceptional circumstances** when unforeseen delays occur in the submission of a claim in excess of three months from the date of test/service due to extenuating circumstances, the Consultant may submit to Aviva Health, a completed claim form which must include side 1 of the form completed and signed by the Aviva

member, side 2 of the claim form completed in as far as is possible by an attending Consultant, to comprise clinical data including member Discharge Summary (where available), and all other invoices related to the admission are attached to the claim i.e. Hospital and other Secondary Consultants. This exception may not be availed of, for routine bill submission due to routine or on-going completion delays by either the submitting hospital or the admitting consultant. For a specific Consultant (or Consultant Group) to avail of this facility they must notify the Claims Manager of Aviva Health explaining the reason for the use of this exception to ensure that issues arising from the use of this exemption are maintained at a minimal level.

24. Benefit is not payable for cosmetic treatment except where surgery is required to:

    I. Restore the members appearance after an accident, or

    II. Because the member was severely disfigured at birth

25. Calculation of benefit will be based on the relevant Schedule of Benefits for Professional Fees that is current on the date of admission to hospital.

26. New conditions of payments or changes to existing conditions of payment or hospital settings may be made by Aviva throughout the term of this agreement. Any such changes will be notified on the web site of Aviva Health and/or directly to the consultant(s) involved.

27. Aviva will not be responsible for costs incurred for members in the rectification of matters prior to their commencement of contract of health insurance in the Irish healthcare market

28. Where an Aviva member is treated under a consultant in an admitting approved Aviva hospital and is then transferred to another Aviva approved hospital for a surgical or diagnostic procedure under the care of the same admitting or treating consultant, for the purpose of professional fees payable to the admitting consultant and to any consultant involved in the patients care, the admission date of the episode of care will refer to the date of admission to the first hospital and the discharge date will be the latest discharge date from either facility. All rules in relation to billing will be applied to the episode of care as distinct to the individual admissions.

29. It is agreed that all Guidelines issued by the National Clinical Effectiveness Committee (NCEC) and by the Health Information and Quality Authority (HIQA) will be applied in for far as is possible to procedures and treatments performed on Aviva Health members. Any deviation from the above guidelines will be notified to Aviva at time of claim to validate the medical necessity of the performance of the procedure / treatment.

***Consultant** – means a registered medical practitioner who is engaged in hospital practice and who, by reason of his/her training, skill and experience in a designated specialty (including appropriate specialist training) is consulted by other registered medical practitioners and undertakes full clinical responsibility for patients in his or her care, or that aspect of care on which he or she has been consulted, without supervision in professional matters by any other person and who has registered as a specialist with the medical Council of Ireland and is listed on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council of Ireland.

SURGERY & PROCEDURES GROUND RULES

1. Surgery & Procedure Benefit

The benefit for surgery & procedures includes all care associated with the procedure, pre-operative assessment, the operative procedure, autogenous graft material harvesting unless otherwise stated, removal of sutures after the main procedure, all guidance associated with the procedure including ultrasound, conscious sedation, local or regional anaesthesia when administered by the Consultant and all necessary follow-up care until the patient is discharged. In-patient attendance/consultation benefit is not payable with Surgery and/or Procedure benefit except as outlined below in Ground Rule 2.

2. Diagnostic Procedures

Where a procedure marked "Diagnostic" in the schedule is carried out by the Consultant, the benefit for the procedure is payable.

If a procedure marked "Diagnostic" is carried out during a **medically necessary** (as defined) hospital stay involving ***active*** treatment of the patient (each day of admission including weekends and public holidays,) in excess of three days, then 100% of the procedure benefit is payable in addition to In-Patient Attendance benefit.

3. Out-Patient Rooms Consultations

An outpatient room's consultation should include a full history and examination for a new patient, or an existing patient with new symptoms. This consultation is an allowable outpatient Aviva member benefit (subject to the member policy held).

Where a procedure listed below or as set out in the schedule of "Minor Procedures Fee" is performed, the procedure fee for the appropriate setting will be paid by Aviva to the Consultant by means of the direct settlement system.

For purposes of clarity, the Consultant may charge the Aviva member for the cost of the initial room's consultation if performed at the time of the procedure and such consultation fee will be an eligible charge from the member to Aviva for inclusion in their annual out-patient claim subject to the member policy held).

No further outpatient consultation fee should be incurred by the Aviva member where subsequent treatments are directly linked to the initial diagnosis and procedure performed (as listed).

Please see Minor Procedures list as part of this Schedule of Benefits for Professional Fees.

1587	Laser treatment to port wine stains only, one or more sessions, , patients aged under 16, plus photographic evidence to be supplied with claim
2147	CO_2 response curve
2149	Body plethysmography
3130	Application of Plaster of Paris casts as a separate procedure not associated with concurrent surgery (I.P.)
4321	Arthrocentesis, one or more injections at the same session, children aged 12 to 16; small, intermediate or large joint (I.P.)
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.)
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.)
4546	Keloids and hypertrophic scars intralesional injection of triamcinolone; up to and including the sixth lesions (I.P.)
5008	Cardiac ultrasound, (echocardiography) for patients on cytotoxic chemotherapy
5022	Cardiovascular stress test with pharmaceutical/chemical agent(s) includes IV administration, echocardiography ECG with consultant cardiologist in constant attendance.
5036	Transthoracic echocardiography for congenital or acquired cardiac anomalies in children under 16; limited study for patients where the cardiac anatomy is known (e.g. follow up of valve stenosis) or in the evaluation or follow up of patients with predominantly non-cardiac problems (e.g. pre or post cancer chemotherapy, severe renal disease, overwhelming sepsis), where the assessment of myocardial and valvular function or exclusion of pericardial effusion is required.
5108	Cardiac ultrasound, (echocardiography)
5132	Foetal echocardiography for the diagnosis or exclusion of cardiac anomalies in the foetus, including detailed segmental analysis, assessment of visceral situs (2D), M -mode, Doppler (PW & colour flow), assessment of myocardial function, regurgitation - including image acquisition, interpretation and report.
5940	Duplex ultrasound scan, unilateral or bilateral, only one claimable per anatomical site (eg for extracranial or intracranial arteries; unilateral or bilateral – one payment applies; for lower extremity arteries, one or both legs – one payment applies).

4. Echocardiography

Where the admitting consultant requests a second opinion from a consultant Cardiologist which satisfies our criteria for Inpatient consultation benefit, and a procedure code 5008, 5022, 5036, 5108, 5132 is performed at the same time or during the course of the in-patient stay, benefit for the in-patient consultation will be payable to the consultant Cardiologist instead of the procedure benefit.

5. Multiple Procedures

a) Where more than one procedure is performed at the same time and under the same general or local anaesthetic, or where it would have been medically appropriate to carry out any such procedures at the same theatre session, benefit is payable for a maximum of three such procedures as follows:

- 100% of the highest valued procedure
- 50% of the second highest valued procedure
- 25% of the third highest valued procedure

The above is irrespective of whether or not the procedures were carried out at the same time. A special application must be completed and submitted by the patient's Consultant, if any such procedures are carried out at different times and it is suggested that is was medically appropriate to do this. The circumstances of each case will then be considered by Aviva's Medical Advisors.

b) When serious multiple injuries require an unusual and prolonged single session in theatre necessitating the repair of multiple fractures these cases will be reviewed for benefit payment on an individual basis following the submission of a comprehensive medical report.

For the less complex cases, the payment method is as outlined in (a) above.

6. Independent Procedure (I.P)

A procedure marked "I.P" (Independent Procedure) is reimbursed only when it is performed alone or independently and not when it is performed at the same time as another procedure. However, we will allow benefit for the higher valued procedure.

7. Scope of Benefit

Some of the procedures, by definition, embrace lesser procedures which may be listed in their own right in the schedule. The lesser procedures attract benefit only when performed alone for a specific purpose but not when they form an integral part of another procedure.

8. One Night Only

If a particular treatment or investigation is marked "One Night Only" we will pay the full benefit for hospital charges in accordance with the members plan for admissions not exceeding 24 hours. If the member meets the eligibility criteria for a medically necessary in-patient stay, as listed below, we will pay the in-patient charges for one extra pre-operative night. The Consultant benefits for theses procedures are not affected by this rule.

9. Eligible for one pre-operative night for procedures designated One Night Only

Benefit for one pre operative night will be provided for the following categories of patients:

- ASA Class III
  Severe systemic disturbances or disease from whatever cause, even though it may not be possible to define the degree of disability with finality. Examples: severely limiting organic heart disease, severe diabetes with vascular complications, moderate to severe degrees of pulmonary insufficiency, angina pectoris or healed myocardial infarction.

- ASA Class IV
  Severe systemic disorders that are already life threatening, not always correctable by operation. Examples: patients with organic heart disease showed marked signs of cardiac insufficiency, persistent angina, or active myocarditis, advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

- Emergency Admissions
  Where the patient was referred by the GP or from A&E to the Consultant as an emergency on the day of admission and a decision was made by the Consultant that admission was medically necessary.

- Obese Patients
  Patients with a BMI >35

- Distance
  - Where the distance a member has to travel is more than 100 kilometres from the facility where the procedure is to be performed.

  - If close monitoring of blood sugars is required to provide adequate adjustment of regular insulin coverage in preparation for an operative procedure in a brittle insulin- dependent diabetic member (i.e. diabetic individuals who experience large, unpredictable changes in blood glucose, within short periods of time, as a result of very small deviations from their schedule)

  - The member requires conversion from warfarin to intravenous heparin (not subcutaneous heparin) for a surgical procedure planned for the next day (individuals

with mitral valve disease, especially with atrial fibrillation, may require 2 pre-operative days)

Note: The above refers to eligibility for Aviva benefit. It does not preclude the patient from requesting in-patient admission for their own convenience. However, in such cases they would be liable themselves for the additional charges.

10. Day Care

If a particular treatment or investigation is marked "Day Care" and:

- It is the only treatment given or
- It is carried out for investigation only and is not part of continuing in-patient treatment

We will pay the full benefit for hospital charges in accordance with the members plan only if the treatment is provided while the member is a day patient.

If the day care procedure is performed in an in-patient setting (private, semi-private, or public ward) the approved day care charge only is payable. If the member meets the eligibility criteria for a medically necessary in-patient stay, as listed below, we will pay the in-patient hospital charges. The Consultant benefits for these procedures are not affected by this rule.

11. Eligibility Criteria for In-Patient Admission for Designated Day Care Procedures

The following are the specific criteria that determine eligibility for an in-patient stay for procedures that are designated as Day Care in the Schedule of Benefits for Professional Fees.

- Not Eligible
  Patients categorised as falling into the following ASA classes are considered suitable for day case surgery and benefit will not be provided for an in-patient stay:

- ASA Class 1
  The Patient has no organic, physiological, biochemical or psychiatric disturbance. The pathological process for which surgery is to be performed is localised and does not entail a systemic disturbance. Examples: a fit patient with a medical condition not the subject of this claim such as an inguinal hernia or a fibroid uterus in an otherwise healthy woman.

- ASA Class II
  Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiological processes. Examples: slightly limiting organic heart disease, mild diabetes, essential hypertension or anaemia.

- Urology patients
  In urological practice many elderly patients who have important co-morbidity can successfully undergo lower urinary tract instrumentation as a day case when it is medically necessary to give a general anaesthetic.

- Patients Requiring Investigation Only
  Patients undergoing designated Day Care procedures requiring other investigations, such as pathology, radiology, ultrasound or MRI, but who do not require the intensity of service that would justify an in-patient admission (for example, patients who do not require intravenous treatment, intensive monitoring of vital signs or other active management that could only have been provided in an acute hospital setting).

Note: The above refers to eligibility for Aviva benefit. It does not preclude the patient from requesting in-patient admission for their own convenience. However, in such cases they would be liable themselves for the additional charges.

12. Eligible for both a pre and post-operative night

Benefit for both a pre and a post-operative night will be provided for the following categories of patients.

- ASA Class III
  Severe systemic disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability with finality. Examples: severely limiting organic heart disease, severe diabetes with vascular complications, moderate to severe degrees of pulmonary insufficiency, angina pectoris or healed pectoris or healed myocardial infarction.

- ASA Class IV
  Severe systemic disorders that are already life threatening, not always correctable by operation. Examples: patients with organic heart disease showing marked signs of cardiac insufficiency, persistent angina, or active myocarditis, advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

- Emergency Admissions
  Where the patient was referred by the GP or from A&E to the Consultant as an emergency on the day of admission and a decision was made by the Consultant that admission was medically necessary.

- Obese Patients
  Patients with a BMI >35

13. Eligible for post-operative night(s)

Benefit will be provided for a one post operative night (or more than one if events are persistent) in the event of any of the following occurring:

- Post operative nausea and/or vomiting not responsive to initial post operative use of parenteral antiemetics
- Post operative pain persisting longer than the routine post operative analgesia regime and requiring the use of parental analgesia
- Parenteral antibiotic therapy required post operatively
- Where a drain is left in situ following the excision of a breast lump or lipoma
- Indwelling catheter required overnight post cystoscopy
- Heamaturia post cystoscopy with obstruction severe enough to require manual sterile irrigation or continuous bladder irrigation overnight.
- Abnormal vital signs post operatively following general anaesthesia
- Previous adverse reaction to anaesthesia

14. Eligible for either a pre or post-operative night.

Benefit will be provided for either a pre or post operative night if the following applies:

- Distance
  Where the distance a member has to travel is more than 100 km from the facility where the procedure is to be performed. If the procedure is performed early in the morning benefit will be provided for a pre operative night. If the procedure is performed in the afternoon benefit will be provided for a post operative night.

15. Side Room Only

Certain procedures are designated "Side Room Only". These are procedures carried out on a day care basis where it is not envisaged that the patient will require and extended period of recovery before resuming 'street fitness'.

However, in exceptional cases should a general anaesthetic be required, this must be certified by the patient's Consultant as medically necessary and the procedure should then take place in an area with appropriate standards of anaesthetic delivery equipment, monitoring, resuscitation equipment and appropriately trained nursing staff.

This must be approved by the Aviva Medical Advisors. If agreed by Aviva, we will pay the approved hospital benefits. However, if not approved, the hospital will only be paid the Aviva Side Room hospital benefit.

Professional fee benefits are not affected by this designation. **This will only apply in an Aviva approved facility.**

16. Eligibility Criteria for Day Care or Inpatient Admission for Designated Side Room Procedures

The following are the specific criteria that determine eligibility for either a day case admission or an inpatient admission for procedures that are designated as Side Room in the Schedule of Benefits for Professional Fees.

17. Not eligible as a day case / inpatient case – side room only

Patients falling into the following categories are considered suitable to have designated Side Room procedures in the side room setting and benefit will not be provided for either a day case or inpatient admission.

- ASA Class
  ASA Classes I – IV

- Patients Requiring Investigation Only
  Patients undergoing designated Side Room procedures requiring other investigations, such as pathology, radiology, ultrasound or MRI, but who do not require the intensity of service that would justify an inpatient admission (for example, patients who do not require intravenous treatment, intensive monitoring of vital signs or other active management that could only have been provided in an acute hospital setting).

18. Eligible for Day Case Admission

Benefit will be provided on a day case basis for the following patients only;

- General anaesthesia
  Where it is medically necessary for the patient to have a general anaesthetic.

19. Eligible for inpatient Admission

Benefit will be provided for in-patient admission for the following patients only:

- Medically necessary

- If the condition of the patient, the severity of the disease or the intensity of other services provided (for example, patients who require intravenous treatment, intensive monitoring of vital signs or other active management which could only have been provided in an acute hospital setting) would otherwise justify an in-patient stay.

20. Postponed Surgery

If, on examination, the patient is deemed unfit for surgery and the admitting Consultant proceeds to treat the patient in a medical capacity, the In-Patient Attendance benefit is payable.

21. Surgery Complications

The global surgery/procedure benefit includes services furnished during an additional operating theatre setting to correct complications, e.g. replacing stitches.
Re-operations for certain serious complications are listed as services which can be claimed in addition to the initial operation.

22. Two Surgeons or Surgical Team

We recognise that there are valid circumstances when the procedure being done requires the participation of 2 surgeons or a surgical team (more than 2 surgeons). In these cases, the additional surgeons are not acting as assistants- at- surgery but because of the procedure(s) or the patient's particular condition or both, two surgeons or a surgical team are required to meet the patient's surgical needs. Benefit payable in these cases will be determined in consultation with Aviva Medical Advisors, upon receipt of supporting medical evidence

23. Assistant At Surgery

The Surgery and Procedures benefits are inclusive of the services of an assistant.

24. Incidental Surgery

Benefit is not payable for surgery which is not medically necessary, but which is performed incidental to other therapeutic surgery.

25. Service

Benefits in respect of procedures marked "Service" are only paid to Consultants.

26. Pre certification

In order to qualify for benefit, for procedures marked "pre-cert", a special pre-cert form must be completed and sent to our claims department in advance of treatment. The pre-certification must be authorised by Aviva's Medical/Dental Advisors prior to being performed, as on the specialist register of the division of Oral Surgery listed throughout the Schedule of Benefits for Professional Fees.

Note for specific Oral/ Maxillofacial./ Dental procedures, this rule will not apply to Consultant Maxillofacial Surgeons or Oral Surgeons (on the Register of Oral Surgeons as maintained by the Irish Dental Council).

27. Procedures which do not comply with Aviva in Conditions of Payment

If a Consultant decides to carry out a procedure which does not comply with the Aviva's conditions of payment, for certain procedures as indicated throughout the Schedule, the Consultant must give advance notice to the patient that the costs involved will not be payable by Aviva. Any charges made are, therefore, a matter between the patient and the Consultant.

28. Use of Robotic Surgery

Unless indicated otherwise, reimbursement for such procedures will be at the rate pertaining to laparoscopic surgery.

29. Definition of MOHS Surgery
(for Codes 1581, 1582, 1583, 1584, 1586, 1597, 1598, 1599, 1604)

Moh's micrographic surgery is a technique for the removal of complex or ill-defined skin cancer with histologic examination of 100% of the surgical margins. It requires a single consultant to act in two integrated but separate and distinct capacities: surgeon and pathologist. If either of these responsibilities is delegated to another consultant who reports the services separately, these codes should not be reported. The Mohs Consultant Dermatologist removes the tumour tissue and maps and divides the tumour specimen into pieces, and each piece is embedded into an individual tissue block for histopathologic examination. Thus a tissue block on Mohs surgery as an individual tissue piece embedded in an amounting medium for section (irrespective of the number of sections cut from the block for slide preparation). When Mohs surgery is performed on a single tumour but is carried over to a second day, the first layer (stage) on the next day should continue with the next code in the series. For example, if the surgery after the first layer was postponed until the second day, then coding the second day surgery starts with 1582 or 1584 but not code 1581 or 1583 because not de-bulking is necessary on the second day. It may be necessary to use a number of combinations of Mohs codes to report the extent of surgery carried out, therefore the benefit assigned to each code 1581, 1582, 1583, 1884, or 1596 is payable in full including multiples of codes 1582, 1584, and 1596. In exceptional cases where two different tumours in different sites (e.g. one on hand and one on foot) are removed during the same session each is regarded as a separate session and benefits are payable for each separate tumour.

NOTE 1: If repair closure, adjustment tissue transfer or rearrangement is performed use one of the codes below 1597, 1598, 1599 or 1604, which is payable in full with the most codes listed above. In some cases the repair may be carried out by a 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.

NOTE 2: Conditions of payment:
1. Lesions located in anatomic areas with high risk of reoccurence of tumour. These areas would involve involvement of the face (especially around nose, mouth, eyes 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 genitiala; or
3. Is re-occurrent or incompletely excised malignant lesions, regardless of anatomic region; or
4. Previously irradiated skin areas in any anatomic region; or
5. FOr exceptionally large (2cm or larger in diameter) or rapidly growing lesions in any anatomic region; or
6. Tumours with aggressive histological patterns: basal cell carcinoma (BCC) morpheaforn [sclerosing], basosquamous [net atypical or keratinizing], perineural or perivascular involvement, infiltrating tumours, multi-centric tumours, contiguous tumours (i.e. BCC and SCC); squamous cell carcinomas (SCCs) ranging from underdifferentiated to poorly differentiated and SCCs that are adenoid (acantholytic), adenosquamous, desmoplastic, inflitrative, perineural, periadnexal or perivascular; or
7. Tumours with ill-defined borders; or
8. SCC assocaited with high risk of metastasis, including those arising in the following; Bowne's disease (squamous cell carcinoma in situ); discoid lupus erythematosus; chronic osteomyelitis; lichen sclerosis eta atrophicus; thermal and radiation injury; chronic sinuses and ulcers; and adenoid type lesions;
9. The Consultant Dermatologist performing Mohs surgery must be registered with Aviva and have completed a fellowship training in Mohs surgery.

If repair closure, adjustment tissue transfer or rearrangement is performed use one of the codes 1597, 1598, 1599 or 1604, which is payable in full with the most codes listed above. In some cases the repair may be carried out by a 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.

30. Cardiology

The ACC/AHA/ESC guidelines for the management of patients with Supraventricular Arrhythmias will apply for the relevant procedures

ANAESTHESIA

1. Anaesthesia Benefit

Anaesthesia benefit applies to general anaesthesia or regional anaesthesia given by the consultant anaesthetist (including spinals, epidurals, plexus blocks and other blocks but not local infiltration).

In the case of regional anaesthesia, sedation if used, is also included. The benefit includes pre-operative assessment, induction and maintenance of the anaesthetic and all necessary monitoring and supportive therapy. Benefit also includes pre-operative transoesophageal echocardiography in certain circumstances as detailed in the notes procedure code 5109. Supervision of care in the recovery unit is included as is supervision of any high dependency type care required by virtue of the procedure the patient underwent, whether such care is delivered in a high dependency unit or an intensive care unit. Supervision of post-operative acute pain relief therapy is also included.

2. Rates of Benefit

The anaesthesia rates of benefit associated with procedures only apply to anaesthesia services personally administered by a consultant anaesthetist.

To avoid any misunderstanding, the Fees claimable by the Consultant Anaesthetist are **not paid** where the Consultant Anaesthetist does not personally attend the Aviva member and personally administer the Anaesthesia, with the exception of monitored Anaesthesia care as set out below

3. Monitored Anaesthesia Care

(a) This benefit is payable to a Consultant Anaesthetist who attends a patient throughout the course of a surgical procedure (regional anaesthesia by the operator or no anaesthesia required) and provides the monitoring and supportive therapy which is routine during general or regional anaesthesia. The benefit is only payable where the patient is unstable, or the procedure is likely to provoke instability, and particularly if the patient is ASA 3,4 or 5. The relevant medical details must be provided on the claim form.

Rates of benefit for monitored anaesthesia care are indicated by an asterisk (*)

(b) When it is necessary for a general anaesthetic to be administered for valid medical reasons, for one of the procedures marked with an asterisk, general anaesthesia benefit will be considered provided that full medical details are furnished on a Special Reporting Process form.

(c) Where no valid medical reason(s) are provided for giving a general anaesthetic e.g. general

anaesthesia administered primarily for the convenience of the patient or doctor, then monitored anaesthesia benefit will apply. In these circumstances any additional charge made for the anaesthetic is a matter between the patient and the consultant anaesthetist.

(d) Aviva will require pre-authorisation for the removal of impacted wisdom teeth by Dental/ Oral Surgeons under general anaesthesia. Aviva are applying the NICE guidelines relating to Wisdom teeth removal- full guidance is available at the NICE website www.nice.org.uk

4. Multiple Procedures

Payment rules will be as follows:

(a) Where more than one procedure is performed at the same time and under the same general or local anaesthetic, or where it would have been medically appropriate to carry out any such procedures at the same theatre session, benefit is payable for a maximum of three such procedures as follows:
- 100% of the highest valued procedure
- 50% of the second highest valued procedure
- 25% of the third highest valued procedure

This is irrespective of whether or not the procedures are in fact carried out at the same time.

A special application must be completed and submitted by the patient's consultant, if any such procedures are carried out at different times and it is suggested that it was medically appropriate to do this. The circumstances of each case will then be considered by Aviva.

(b) When serious multiple injuries require an unusual and prolonged single session in theatre necessitating the repair of multiple fractures these cases will be reviewed for benefit payment on an individual basis following the submission of a comprehensive medical report.

For less complex cases, the payment method is as outlined in (a) above.

5. Consultations - In-Patient and Day Care

An ordinary in-patient consultation is payable when a routine pre-operative assessment of a patient by a consultant anaesthetist leads to cancellation of surgery

A major in-patient consultation benefit is payable when, at the request of another consultant, the consultant anaesthetist is asked to assess the overall operative risk in a patient of category ASA 3, 4 or 5 as defined by the American Society of Anaesthesiologists

This consultation must include the following:
- A comprehensive history

- A comprehensive multi-system examination
- Medical decision making of high complexity

This benefit is not payable where the consultation is followed by surgery.

This refers to the American Society of Anaesthesiologists ranking of patient's status as defined below:
ASA 3: a patient with severe systemic disease
ASA 4: a patient with severe systemic disease that is a constant threat to life
ASA 5: a moribund patient who is not expected to survive without the operation

6. Special Reporting Process

The Special Reporting Process is a method to allow the consultant anaesthetist make a comprehensive report of the type and extent of certain services provided to patients.

It applies to an anaesthetic service that is rarely provided, unusual or new, where agreement has been reached with Aviva that the service is eligible for benefit. The special Reporting Process details should also be completed for procedures that are designated Monitored Anaesthesia Care where a general anaesthetic is administered. In these cases the information provided should include an adequate definition or description of the nature, extent and need for the procedure including the time, effort and equipment necessary to provide the service.

The Special Reporting Process details will be evaluated by a monitoring group consisting of one member nominated by each of the following: the Private Practice Committee of the Association of Anaesthetists of Great Britain and Ireland and Aviva. The decision made by the monitoring group is final.

7. Claiming Benefit

For hospitals which operate through the Aviva direct settlement of hospital and associated consultant professional fee charges, the claiming of Anaesthesia benefit will continue on the basis of a fully completed and collated Aviva claim form as completed by the admitting consultant surgeon/physician, which will be submitted by the hospital in conjunction with its own invoice for services provided. However, in exceptional circumstances when unforeseen delays occur in the submission of a claim in excess of three months from the date of test/ service due to extenuating circumstances ,the Consultant Anaesthetist may submit to Aviva , a completed claim form which must include side 1 of the form completed and signed by the Aviva member, side 2 of the claim form completed in as far as is possible by an attending Consultant, to comprise clinical data including member Discharge Summary (where available),and all other invoices related to the admission are attached to the claim i.e. Hospital and other Secondary Consultants. This exception may not be availed of, for routine bill submission due to routine or on-going completion delays by either the submitting hospital or the admitting consultant. For a specific Consultant (or Consultant Group) to avail of this facility they must notify the Claims

Manager of Aviva explaining the reason for the use of this exception to ensure that issues arising from the use of this exemption are maintained at a minimal level.

8. Anaesthesia Block Procedures

3540	Epidural injection (I.P.)
3541	Caudal injection (I.P.)
3545	Epidural infusion with cannula
5615	Nerve block for pain control (I.P.)
5620	Sympathetic block including coeliac ganglion and stellate ganglion
5621	Intravenous block (Bier's technique)
5624	Injection, anaesthetic agent, intercostal nerve, single (I.P.)
5625	Injection, anaesthetic agent, intercostal nerve, multiple, regional block (I.P.)
5719	Chemical lumbar sympathectomy

The above are payable except when performed in conjunction with surgery or anaesthesia.

Note:
** = Monitored Anaesthesia Care*
 # = General Anaesthesia or Regional Anaesthesia with Monitored Anaesthesia Care. (Please note this benefit is only claimable when the Consultant Anaesthetist administers the anaesthetic, not payable when local/regional anaesthesia is administered by the operator.)

9. Claim for Monitored Anaesthesia

The medical indications for monitored anaesthesia must be stated on the claim form in order to claim benefit.

EMERGENCY MEDICAL ADMISSION AND CONDITIONS FOR NEONATES OR PAEDIATRIC CARE

1. Benefit Payable

The participating benefit payable to the Consultant Neonatologist or Consultant Paediatrician for personally provided Consultant care will be the same payment benefit as applies to one in-patient day.

Benefit is also payable for Consultant Radiologist and Consultant Pathologist services incurred during the admission.

The following is a list of neonatal or paediatric emergency admission conditions for which we will pay hospital and consultant benefits when the in-patient's stay is overnight and less than 24 hours:

- Babies with respiratory distress following caesarean delivery
- Gastroenteritis
- Acute asthma
- Croup
- Septicaemia
- IV antibiotic therapy or other IV drip administration
- Suspect meningitis
- Other acute conditions

Note: this fee does NOT provide for fee payment for routine admission for non-emergency care e.g. constipation of a non-emergency case

Code	Description	Specialty
10000	Medical management for specific paediatric medical day care procedures/ investigations	In-patient attendance and other medical services

IN-PATIENT GERIATRIC MEDICINE

A major in patient geriatric medical consultation arising from the referral of a patient by the admitting Consultant to a Consultant Geriatric Medicine Physician registered with Aviva for the purpose of managing a complex case.

(This consultation is only payable for the initial consultation with a new patient. Any subsequent consultations in future in-patient claims are payable at the ordinary or major consultation rates).

The consultation includes:

- A full history and medical examination of all parts and systems
- Evaluation of appropriate diagnostic tests
- Formal symptom assessment/ validated quality of life assessment, measure administered and interpreted
- Giving an opinion and making an appropriate record
- The duration for this consultation must be for a minimum of 30 minutes

Code	Description
8692	Consultant Geriatrician In-Patient Consultation

Note:

1. *The benefit for In Patient consultation does not include any form of therapy or continued involvement with the patient. It is paid once only, irrespective of the number of examinations or visits involved in forming an opinion.*
2. *Where a procedure listed in the Schedule of Benefits for Professional Fees is performed at the time of a consultation then only the procedure benefit is payable.*
3. *This benefit is not payable where, as a matter of policy, all patients are routinely examined by a second doctor.*
4. *The routine screening of patients pre-operatively, regardless of health status, is included in the benefit paid to the admitting Consultant. Consultation benefits are therefore not payable in these instances.*

Conditions of payment:
The claiming of benefit will continue on the basis of a fully completed Aviva claim form from the primary treating consultant.

IN-PATIENT NEONATAL PAEDIATRICIAN BENEFIT

1. In-Patient Neonatal Paediatrician Consultation

A major in-patient consultation is payable to a Consultant Neonatologist or Paediatrician who provides consultation and care over several days on a new-born with the following presentation problems:

- An infant having septic work ups and receiving IV antibiotics on the postnatal ward for up to 48 hours post delivery.
- In the infant requiring referral to another specialist after delivery for congenital malformations or chromosomal abnormalities.
- An infant with less than 2.5kg birth weight and/or less than 37 complete weeks of gestation.

This consultation is also payable to a Consultant Neonatologist or Consultant Paediatrician who is required to travel to the hospital, at the request of hospital staff, for the evaluation and management of a sick neonate between the hours of 6pm and 9am. Benefit is limited to one patient per call-out and the time of call-out must not coincide with the Consultants' normal time for seeing patients or because of personal choice or availability.

Code	Description
8694	Consultant Neonatologist or Paediatrician In-Patient Consultation

INTENSIVE CARE MEDICINE

1. Intensive Care Medicine Benefit

The intensive care benefits are payable to consultants with a Special Interest in Intensive care medicine registered with Aviva. The benefits relate to the medical management of appropriately admitted patients to an Aviva approved intensive care units, the patient having been admitted under the care of the intensive care consultant or the critical care of the patient having been transferred to the intensive care consultant by another hospital consultant.

In non-surgical cases when a patient is admitted under the care of a consultant physician and requires active medical attention from the admitting physician including the period of the patient's stay in the intensive care unit, the In-Patient Attendance Benefit is payable to the admitting physician in addition to the intensive care benefits payable to the consultant who treats the patient in the intensive care unit.

**Intensive care consultant refers to the intensive care consultant(s) who take(s) responsibility for the patient during their stay in the intensive care unit.*

2. Intensive Care Unit

Aviva approved Intensive Care Unit (ICU) must be a separate designated hospital facility for the care of the critically ill patient. It must be equipped and staffed to be able to support common organ system failures, in particular ventilatory, circulatory and renal failure.

The minimal monitoring for each bed space should consist of:

- Continuous ECG display and heart-rate monitoring
- Continuous direct arterial blood pressure monitoring
- Continuous central venous and pulmonary arterial pressure monitoring
- The continuous monitoring of ventilation and oxygenation
- Ventilator disconnection alarms
- Continuous inspired oxygen concentration monitoring
- Continuous central temperature monitoring
- Cardiac output measurement

The unit must have a designate consultant as medical director supported by other suitable qualified consultants with allocated intensive care sessions providing 24 our continuous consultant availability.

In addition, non-consultant medical doctors must be immediately available to the intensive care unit and provide 24 hour cover for the unit.

The unit must have appropriate admission guidelines including assessment of the continuing appropriateness of intensive care which should be made as soon as practicable after admission and at least daily thereafter and the level of intensity of care assessed.

Clinical audit must be component of the intensive care medical service and the anonymised data should be available to the Aviva on an annual basis.

The unit must be able to provide a one-to-one nurse to patient ratio at all times together with the nurse in charge with additional nurses according to patients needs. The nursing skills should reflect the psychological needs of the patient.

3. Intensive Care Medicine Services

Intensive care medical benefit is payable for the care of a seriously ill patient appropriately admitted to an Aviva approved intensive care unit. The patient must require mechanical ventilation support.

Benefit is not payable for planned post-operative intensive care where mechanical ventilation support was commenced in theatre. However, if the patient's medical condition is such as to require maintenance on mechanical ventilation support of a period greater than twenty four hours, these claims will be considered for payment of intensive care benefit for the period in excess of the twenty four hours – full details must be supplied to Aviva in addition to the hospital claim form.

If a patient requires admission to an intensive care unit (unplanned) arising from a post-operative medical emergency, benefit will be considered on submission of full details, by report.

Patient care also includes but is limited to the following:

- Assessment of the patient including blood gases and/or pulmonary function testing
- Minute to minute attendance with the patient with frequent re-assessment of blood gases/clinical state and pulmonary function, hereafter, frequent review (i.e. several visits by the consultant to the patient during each 24 hour period)
- Acute renal replacement therapy (haemodiaoysis, haemofiltration or haemodiafiltration), if required
- The support of other organ systems, if required
- Prescription of appropriate sedative/analgesia regimes – these may include narcotic infustions, PCAs and/or epidurals
- IV drugs
- Vaso/active agents
- Taking blood
- Venous pressure and blood volume studies
- Oximetry
- IV cannulation
- Continuous ECG monitoring
- Nasogastric tube

- Transtracheal aspiration
- Laryngoscopy
- Endotracheal intubation including induction of general anaesthesia
- Invasive neurological monitoring
- Urinary catheterisation
- Total parenteral nutrition
- Performance and interpretation of other tests and procedures as appropriate

4. Consultations

Consultation benefit is payable to the intensive care consultant for a patient being assessed for admission to the intensive care unit as defined in intensive care medicine and where it is deemed that the patient does not require admission to the intensive care unit.

5. Other Procedures for Which Benefit is Available When carried out in an ICU

The following medical services are payable in addition to the ICU Medicine Benefit:

* 5921, Tracheostomy, permanent
* 5922, Insertion of mini-tracheostomy
* 5933, Insertion of vascath or similar for haemodialysis
* 5091 Cardioversion
* 5109 Echocardiography, transoesophageal
* 5952 Insertion of tube drain into pleural cavity
* 5251 Closed drainage of pneumothorax
* 5065 Insertion or replacement of temporary transvenous single chamber cardiac electrode
**1626 Tunnelled central venous access (see notes below)

Benefit for these procedures * is payable once only during the patient's stay in the intensive care unit.

For procedure code **1626, 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 or the inferior vena 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. basilica 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, and a copy of the relevant X-ray report to clarify the termination of the CVP line will be required.

Benefit for the above procedures once only during the patients stay in the Aviva approved intensive care unit.

6. Conditions of payment:

The claiming of benefit will continue on the basis of a fully completed Aviva claim form from the primary treating consultant.

PAEDIATRIC INTENSIVE CARE

1. Paediatric Intensive Care Medicine Benefit

Paediatric intensive care benefits are payable to Consultant Paediatric Intensivist who are registered as such with Aviva, and who are attached to a Paediatric Intensive Care Unit registered with Aviva and which meets BAPM (British Association of Perinatal Medicine) definition of a level 3 Paediatric Intensive Care Unit.

The benefits relate to the medical management of paediatric patients (neonates, infants and children up to 16 years of age) that are so sick or have the likelihood of acute deterioration that they generally require to be treated by a Consultant Paediatric Intensivist and receive 1:1 or 1:2 by a nurse with intensive care qualification and are accommodated in the Paediatric intensive care facility of a hospital providing 24 hour continuous consultant availability.

Hospitals providing paediatric intensive care must have continuous availability of qualified medical and nursing staff and resources to meet the needs of all critically ill children. Hospitals must be able to demonstrate the necessary professional and technical infrastructure, together with protocols for the care of such children.

When a patient is admitted under the care of a Consultant Neonatologist, Consultant surgeon or Consultant Paediatrician and requires active medical attention from the admitting consultant including the period of the patient's stay in the Paediatric Intensive Care Unit (PICU), the in-patient attendance benefit is payable to the admitting physician in addition to the intensive care benefits payable to the consultant Intensivist who treats the patient in the PICU.

2. Intensive Care Unit Approval

An Aviva approved Paediatric Intensive Care Unit (PICU) must be a separate designated hospital facility for the care of critically ill patient. The unit must be equipped and staffed to be able to support common organ system failures, in particular ventilatory, circulatory and renal failure.

Each unit cot should have available the following:

(a) Continuous ECG display and heart monitoring

(b) Continuous direct arterial blood pressure monitoring

(c) Continuous central venous and/or pulmonary arterial pressure monitoring

(d) Continuous ventilator and oxygen monitoring

(e) Ventilator disconnection alarms

(f) Continuous inspired oxygen concentration monitoring

(g) Continuous central temperature monitoring

(h) Cardiac output measurement

Each PICU unit should have access to equipment for:

(a) Resuscitation

(b) Blood gas analysis (on the Paediatric unit by unit staff)

(c) Portable X-rays

(d) Ultrasound scanning

(e) On site MRI & CT facilities (if required)

There must also be access to 24-hour laboratory service orientated to PICUs.

3. Paediatric Intensive Care Unit (PICU) Medicine Services

Paediatric intensive care benefits are payable for seriously ill patient admitted to an Aviva approved PICU.

The eligible cases will be:

(a) Patients with 2 organ failures including possible respiratory failure

(b) Patients receiving invasive mechanical ventilation via an tracheal tube and in the first 24 hours after its withdrawal (where a patient has been intubated in the operating theatre, the duration of the ventilator support shall be calculated from the time of admission to the PICU)

(c) Patients receiving non-mechanical ventilation support

(d) Patients requiring complex or potentially harmful interventions

- renal placement therapy, plasma exchange or similar extra-corporeal therapies
- Infusion of an inotrope, pulmonary vasodilator, prostaglandin or cardiac anti-arrhythmic medications and for 24 hours afterwards
- Infusion of anti-hypertensive medication
- Infusion of medication which may cause wide fluctuations in cardiac output
- Infusion of a bronchodilator
- Infusion of a central nervous system depressant or any medication that may decrease respiratory minute ventilation or level of consciousness
- Management of a patient who has ingested or suspected to have ingested a drug, toxin or metabolite in a dose which may lead to significant morbidity or death

(e) A child recovering from major surgery who in anticipated to have large flux in circulating blood volume or with potential to require further infusion of blood, colloid or crystalloid solutions

(f) Exchange transfusion

(g) A child recovering form complex surgery to the airway or who has an instable airway

(h) A child following major trauma with an injury severity (or similar) score over 8

(i) any other very unstable baby considered by the nurse-in-charge to generally require 1:1 nursing: for audit, a register should be kept of the clinical details of babies recorded in this category

(j) a baby on the day of death

4. Patient Care in Paediatric Intensive Care Unit (PICU)

Patient care also includes but is not limited to the following:

- assessment of the patient including blood gases and/or pulmonary function testing
- minute to minute attendance with the patient with frequent reassessment of blood gases/ clinical state and pulmonary function, hereafter frequent review (i.e. several visits by the consultant to the patient during each 24 hour period)
- acute renal replacement therapy (haemodialysis, haemofiltration or haemodiafiltration) if required
- the support of other organ systems if required
- prescription of appropriate sedative/analgesia regimes – these may include narcotic infusions. PCA's and/or epidurals
- IV drugs
- Taking blood
- Venous pressure on blood volume studies
- Oximetry
- IV cannulation
- Continuous ECG monitoring
- Nasogastric tube
- Transtracheal aspiration
- Laryngoscopy
- Endotracheal intubation, including induction of General Anaesthesia
- Total parental nutrition
- Invasive neurological monitoring
- Urinary catheterization
- Interpretation and performance of other tests and procedures as appropriate

5. Clinical Standards in Paediatric Intensive Care Unit

Each unit must comply fully with the following standards in relation to:

- Medical Staff
- Nursing Protocols
- Clinical Protocols
- Quality Assurance
- Training and continuing education

6. Medical Staff in Paediatric Intensive Care Unit

Consultants whose principle duties are to the NICU should staff the unit. The unit must have a Consultant Paediatric Intensivist supported by other suitably qualified Consultants with allocated pediatric intensive care sessions providing 24 hour continuous availability.

7. Nursing Protocols in Paediatric Intensive Care Unit

- All units undertaking Paediatric intensive and high-dependency care should be able to demonstrate the required number of appropriately trained and qualified nurses.
- The nursing establishment of a Paediatric Intensive Care Unit should be calculated to ensure that infants receiving intensive care are the sole responsibility of a qualified Paediatric Nurse.
- Units undertaking ant Paediatric intensive or high dependency care should have a senior nurse with Paediatric experience and managerial responsibility.
- Because of the complexities of care needed, there should generally be 1:1 or 1:2 nursing ratio.

IN-PATIENT PALLIATIVE MEDICINE

A major in-patient Palliative Medicine consultation arising from the referral of a patient by the admitting Consultant to a Consultant Palliative Medicine Physician registered with Aviva for the purpose of managing a complex case.

(This consultation is only payable for the initial consultation with a new patient. Any subsequent consultations in future in-patient claims are payable at the ordinary or major consultation rates).

The consultation includes:

- A full history and medical examination
- Evaluation of appropriate diagnostic tests
- Formal symptom assessment/ validated quality of life assessment, measure administered and interpreted
- Giving an opinion and making an appropriate record
- The duration for this consultation must be for a minimum of 50 minutes

Code	Description
10072	A major inpatient palliative medicine consultation

Notes to the above

1. *The benefit for Inpatient consultation does not include any form of therapy or continued involvement with the patient.*
2. *It is paid once only, irrespective of the number of examinations or visits involved in forming an opinion.*
3. *Consultation benefit is not payable to a consultant with the same speciality as the admitting consultant*
4. *Multiple consultation benefits are not payable to consultants with the same speciality*
5. *A consultation benefit is not payable to a consultant if a diagnostic procedure is payable to another consultant, both consultants having the same speciality*
6. *Where procedure listed in the schedule of benefits for professional fees is performed at the time of a consultation then only the procedure benefit is payable*
7. *This benefit is not payable where, as a matter of policy, all patients are routinely examined by a second doctor.*
8. *The routine screening of patients pre-operatively, regardless of health status, is included in the benefit paid to the admitting consultant. Consultation benefits are therefore not payable in these instances.*

1. Palliative Care Stage Planning

This is only payable where a Palliative Care Consultant gives constant attention to a patient in the circumstances set out below and is not payable for claims that involve a surgical procedure

Code	Description
8551	Complex discharge planning, by a Consultant in Palliative Medicine, including meeting with the patients family and healthcare professionals and planning the patient's future needs
8552	Care provided by a Consultant in Palliative Medicine that requires the intensity of service appropriate in the case of a dying patient in the final days of life
8553	Complex discharge planning, by a Consultant in Palliative Medicine, where the patient is transferred from hospital to a hospice into the care of another a Consultant in Palliative Medicine,

Conditions of payment

The claiming of benefit will continue on the basis of a fully completed Aviva claim form from the primary treating consultant.

MEDICAL SERVICES

1. Medical Attendance Benefit

In-Patient Attendance benefit is payable when it is medically necessary for a consultant to admit a patient to a hospital bed for a period of 24 hours or longer for investigation, observation and treatment. The benefit includes all appropriate clinical tests and their interpretation.

Please refer to the Surgery and Procedures Ground Rules for an explanation of the benefit payable when diagnostic procedures are performed. (The other ground rules in the surgery and procedure section also apply.

2. Medically Necessary

Means treatment or a hospital stay which in the opinion of our Medical Advisors is generally accepted by the medical profession as appropriate with regard to good standards of medical practice and is: (i) consistent with the symptoms or diagnosis and treatment of the injury or illness; (ii) necessary for such a diagnosis or treatment; (iii) not furnished primarily for the convenience of the patient, the doctor or other provider: and (iv) furnished at the most appropriate level which can be safely and effectively provided to the patient.

Separate ground rules apply to Day Care procedures, Side Room Only procedures and One Night Only procedures which are available under the Surgery & Procedures Ground Rules in the Schedule. These claims are adjudicated by our Claims Division in accordance with Protocols determined by the Schedule of Benefits for Professional Fees.

Please note that Investigations which may include pathology/radiology, etc. performed prior to admission to hospital (in-patient, day care or side room) e.g. in an Emergency Department or on a pre- admission basis consultation cannot be included as part of the claim for any subsequent hospital admission. With the exception of designated Day Care and Side Room procedures, Consultant and hospital benefit are not provided for patients requiring investigation only unless they also require the intensity of service that would justify an in-patient admission.

3. Calculation of Benefit

The In-Patient Attendance benefit is payable to a consultant for services provided by him/her to the patient for each full day of the patient's stay in hospital.

4. Transfer of Care

When the admitting consultant transfers the care of the patient to a second consultant for the same illness, single In-Patient Attendance benefit is payable. The available benefit is divided by

the total number of days in hospital and each consultant is allowed benefit on a proportional basis equal to the number of days he/she attended that patient.

5. Complex Cases

When the management of a patient with complex or multiple medical problems necessitates the ongoing services of two or more consultants with different specialties and when confirmed by Aviva's Medical Advisors to be appropriate, the In-Patient Attendance benefit is payable to each consultant for the period he/she attends the patient.

6. Transfer for Surgery

Where a consultant transfers the care of a patient to a consultant surgeon for surgery, In-Patient Attendance benefit is payable to the consultant for the period of attendance up to the date of surgery. Surgery benefit is also payable to the consultant surgeon.

7. Neonatology and Paediatrics

In complex neonatal or paediatric cases In-Patient Attendance benefit is payable for the entire hospital stay to a Consultant Neonatologist or Consultant Paediatrician, when active medical attention is given to a child who has had a surgical procedure performed. (see relevant section)

8. In-patient Clinical Tests

When the admitting Consultant requests one of the tests listed below and seeks an interpretation and report from another Consultant, the stated benefit is paid to the second Consultant.

The benefit is not payable where the test is done routinely as a matter of policy for each patient admitted to hospital.

These benefits do not apply to the admitting Consultant nor are they payable in addition to benefit for a consultation.

The Participating benefit is paid once only, irrespective of the number of tests carried out.

Code	Description of Test
8700	24 Hour E.C.G.
8705	EEG
8706	24 hour in-patient ambulatory EEG; monitoring for localisation of cerebral seizure focus

8707	Inpatient EEG; monitoring for localisation of cerebral seizure focus with a minimum of 4 hour video recording
8710	Evoked potentials
8715	Full Lung function including diffusion tests
8720	Oesophageal manometry
8725	pH Probe

9. In-patient Attendance Rules

9.1 In-patient Consultation (Ordinary)

An ordinary in-patient consultation is the referral of a patient by the admitting Consultant to a second Consultant for medically necessary second opinion and includes:

- A full history and examination of the affected part and system
- Evaluation of all necessary diagnostic tests
- Giving an opinion and making an appropriate record

Code	Description
10066	An ordinary inpatient consultation

9.2 In-patient consultation (Major)

A major in-patient consultation is the referral of a patient by the admitting Consultant to a second Consultant for a medically necessary second opinion and includes:

- A full history and examination of all parts and systems
- Evaluation of all necessary diagnostic tests
- Giving an opinion and making an appropriate record
- The duration for this consultation must be a minimum of 30 minutes

Code	Description
10067	A Major inpatient consultation

The benefit for In-Patient consultation does not include any form of therapy or continued involvement with the patient. It is paid once only, irrespective of the number of examinations or visits involved in forming an opinion.

Multiple consultation benefits are not payable to Consultants with the same specialty.

A consultation benefit is not payable to a Consultant if a diagnostic procedure is payable to another Consultant, both Consultants having the same specialty.

Where a procedure listed in the General Surgical Procedures Codes & Rates section of the Schedule of Benefits for Professional Fees is performed at the time of a consultation then only the procedure benefit is payable (except as specified in the surgery and procedures ground rules).

This benefit is not payable where, as a matter of policy, all patients are routinely examined by a second doctor.

The routine screening of patients pre-operatively, regardless of health status, is included in the benefit paid to the admitting consultant(see Anaesthesia Ground Rule 1 and Surgery and Procedures Ground Rule 1). Consultation benefits are therefore not payable in these instances, except for the circumstances as detailed below.

We will allow a pre-operative major consultation for major joint replacement in the following circumstances only:

- Where pre-operative assessment- clinical examination and/or laboratory/radiological, cardiac investigations – identifies an undiagnosed acute problem that requires medical management prior to anaesthesia (e.g hypertension, cardiac arrhythmia, diabetes).
- Patients with insulin dependent diabetes and
- Patients falling into ASA Class III, IV and V as defined below:

ASA Class III

Severe systemic disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability with finality. Examples: Severely limiting organic heart disease, moderate to severe degrees of pulmonary insufficiency angina pectoris or healed MI.

ASA Class IV

Severe systemic disorders that are already life threatening, nt always correctable by operation. Examples: Patients with organic heart disease showing marked signs of cardiac insufficiency, persistent angina, active myocarditis, advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA Class V

A moribund patient who is not expected to survive without the operation.

10. In-Patient Neurological Consultation

A major in-patient neurological Consultation arising from the referral of a patient by the admitting Consultant to a Consultant Neurologist registered with Aviva for the purpose of managing the care of a complex case.

This consultation is only payable for the initial consultation with a new patient. Any subsequent Consultations in future in patient claims are payable at the ordinary or major consultation rate, whichever is appropriate.

This consultation includes:

- A full history and examination of all parts and systems
- Evaluation of necessary diagnostic tests
- Giving an opinion and making an appropriate record
- The duration of this consultation must be for a minimum of 50 minutes

Code	Description
8697	Consultant Neurologist In-Patient Consultation

Note:

1. *The benefit for in-patient consultation does not include any form of therapy or continued involvement with patient.*
2. *It is paid once only, irrespective of the number of examinations or visits involved in forming an opinion.*
3. *Consultation benefit is not payable to a consultant with the same specialty as the admitting consultant.*
4. *Multiple consultation benefits are not payable to consultant with the same specialty.*
5. *A consultation benefit is not payable to a consultant if a diagnostic procedure is payable to another consultant, both Consultants having the same specialty.*
6. *Where a procedure listed in the Schedule of Benefits for Professional Fees is performed at the time of a consultation then only the procedure benefit is payable.*
7. *This benefit is not payable where, as a matter of policy, all patients are routinely examined by a second doctor.*
8. *The routine screening of patients pre-operatively, regardless of health status, is included in the benefit paid to the admitting consultant. Consultation benefits are therefore not payable in these instances.*

11. In-Patient Dialysis Treatment/ Consultation

824	Haemodialysis, chronic, in the patient's home or at a hospital out patient department, after completion of training sessions (minimum of three dialysis sessions per week inclusive of all consultant care), monthly benefit

833	Peritoneal dialysis, chronic, in the patient's home or at a hospital out patient department, after completion of training sessions (minimum of three dialysis sessions per week inclusive of all consultant care), monthly benefit

Conditions of payment
Code 824 and 833 is paid to a maximum of 3 months in a patients home

825	Evaluation of a new patient requiring haemodialysis during a hospital admission including the insertion of vascath or similar, and the initial dialysis session
830	Evaluation of a new patient requiring peritoneal dialysis during a hospital admission including the insertion of an intraperitoneal cannula or catheter for drainage or dialysis, temporary, and the initial dialysis session

Code 825 and 830 are paid to a maximum of 10 sessions for any given patient admissions

12. Conditions of payment – Overall Cardiology

If more than one Cardiology (excluding specifically grouped procedures)procedure 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

13. Day care In-patient Management

The Professional fee paid for the management of a patient (pre-operative assessment, post-operative care including evaluation of all necessary tests) where the Aviva member is admitted under consultant care for one of the procedures listed below where the procedure is performed by another Consultant in a different speciality, is as follows:

Code	Description
8693	Day care In-patient Management

The benefit is only payable when one of the following procedures is performed by another consultant in a different speciality:

605	Biopsy of liver (needle)
713	Biopsy of prostate (perineal or transrectal) (I.P.)
955	Renal biopsy (needle)
1152	Thyroid cyst(s) aspiration/fine needle biopsy (I.P.)
1191	Breast cyst(s) aspiration/fine needle biopsy (diagnostic or therapeutic) (I.P.)
1196	Stereotactic localization core needle biopsy of breast (I.P.)
1309	Fine needle aspiration (FNA), not otherwise specified in this Schedule, with or without preparation of smears; superficial or deep tissue with or without radiological guidance
5136	Percutaneous transthoracic biopsy
5137	Percutaneous transthoracic biopsy under CAT guidance
5742	Transcatheter permanent occlusion or embolisation (e.g. for tumour destruction, to achieve haemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)
5910	Extracorporeal shock wave lithotripsy (ESWL) for urinary tract stone(s)
6111	CAT scanning for biopsy or drainage
66744	Completed radiological examination and evaluation including imaging (mammography and/or ultrasound), and image-guided percutaneous core needle biopsy; where performed on same day by a Consultant Radiologist (I.P.)
6743	Image-guided percutaneous core needle biopsy, including Consultant Radiologist interpretation and report (ultrasound or stereotactic localisation) (I.P.)
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.)
6680	Angiogram (selective catheter, single or multiple vessel study, coeliac, mesenteric, renal etc), includes introduction of needle or catheter injection of contrast media and necessary pre and post injection care realted to the injection procedure
6681	Single selective carotid angiography and/or vertebral study
6682	Bilateral carotid angiography study
6683	Bilateral carotid angiography and vertebral study

14. Diagnostic Procedures

Where a procedure marked diagnostic in the schedule is carried out by the Consultant the benefit for the procedure is payable.

If a procedure marked diagnostic is carried out during a medically necessary hospital stay* involving active treatment of the patient, in excess of 3 days, 100% of the procedure benefit is payable in addition to the In-Patient attendance benefit.

15. Out-Patient Room Consultations

An outpatient room's consultation should include a full history and examination for a new patient, or an existing patient with new symptoms. This consultation is an allowable outpatient Aviva member benefit (subject to the member policy held).

Where a procedure listed below or as set out in the schedule of "Minor Procedures Fee" is performed, the procedure fee for the appropriate setting will be paid by Aviva to the Consultant by means of the direct settlement system.

For purposes of clarity, the Consultant may charge the Aviva member for the cost of the initial room's consultation if performed at the time of the procedure and such consultation fee will be an eligible charge from the member to Aviva for inclusion in their annual out-patient claim subject to the member policy held).

No further outpatient consultation fee should be incurred by the Aviva member where subsequent treatments are directly linked to the initial diagnosis and procedure performed (as listed).

Please see Minor Procedures list as part of this Schedule of Benefits for Professional Fees.

1587	Laser treatment to port wine stains only, one or more sessions, patients aged under 16, plus photographic evidence to be supplied with claim.
2147	CO_2 response curve
2149	Body plethysmography
3130	Application of Plaster of Paris casts as a separate procedure not associated with concurrent surgery (I.P.)
4321	Arthrocentesis, one or more injections at the same session, children aged 12 to 16; small, intermediate or large joint (I.P.)
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.)

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.)
4546	Keloids and hypertrophic scars intralesional injection of triamcinolone; up to and including the sixth lesions (I.P.)
5008	Cardiac ultrasound, (echocardiography) for patients on cytotoxic chemotherapy
5022	Cardiovascular stress test with pharmaceutical/chemical agent(s) includes IV administration, echocardiography ECG with consultant cardiologist in constant attendance.
5036	Transthoracic echocardiography for congenital or acquired cardiac anomalies in children under 16; limited study for patients where the cardiac anatomy is known (e.g. follow up of valve stenosis) or in the evaluation or follow up of patients with predominantly non-cardiac problems (e.g. pre or post cancer chemotherapy, severe renal disease, overwhelming sepsis), where the assessment of myocardial and valvular function or exclusion of pericardial effusion is required.
5108	Cardiac ultrasound, (echocardiography)
5132	Foetal echocardiography for the diagnosis or exclusion of cardiac anomalies in the foetus, including detailed segmental analysis, assessment of visceral situs (2D), M -mode, Doppler (PW & colour flow), assessment of myocardial function, regurgitation - including image acquisition, interpretation and report.
5940	Duplex ultrasound scan, unilateral or bilateral, only one claimable per anatomical site (eg for extracranial or intracranial arteries; unilateral or bilateral – one payment applies; for lower extremity arteries, one or both legs – one payment applies).

16. Approved Facilities

The following procedures will only be liable for benefit for payments of fees when performed in a specifically approved Laboratory, fully equipped, staffed by staff with appropriate accreditation in the discipline and supervised by the reporting Consultant.

2113	Full pulmonary function studies for the diagnosis and assessment of obstructive and restrictive lung disease, where not performed in an approved Aviva laboratory facility
5880	EMG - in an approved Aviva Health recognised Laboratory
1029	Complex uroflowmetry (using calibrated electronic equipment); for initial evaluation of bladder outlet obstruction and uncomplicated urge incontinence with or without ultrasound, with post void residual ultrasound screening in an Aviva approved hospital Urodynamic laboratory
1031	Complex cystometrogram using calibrated electronic equipment and urethral pressure profile studies (minimum of 2 fills), with measurement of post-voiding residual urine by ultrasound in alaboratory in an Aviva approved hospital setting only

17. Echocardiography

Where the admitting consultant requests a second opinion from a consultant Cardiologist which satisfies our criteria for Inpatient consultation benefit, and a procedure code 5008, 5022, 5036, 5108, 5132 is performed at the same time or during the course of the in-patient stay, benefit for the in-patient consultation will be payable to the consultant Cardiologist instead of the procedure benefit.

18. In-patient Major Medical Illnesses

A Major Medical Illness benefit is payable when it is necessary for a consultant, in non-surgical cases, to give constant attention to an ill patient where one of the illnesses listed on the following pages is the confirmed diagnosis.

This benefit is not payable for claims that involve a surgical procedure or an invasive diagnostic procedure listed in this schedule.

Benefit is payable once only, and only for a single illness listed, per hospital admission and must be specifically claimed.

Major Medical Illness benefit is not payable to the same consultant that receives the ICU/ Neonatal intensive care benefit when the patient is being treated in an intensive care unit or neonatal intensive care unit.

Code	Description
10064	Inpatient Major Medical Illnesses

19. Conditions of payment

For hospitals which operate through the Aviva direct settlement of hospital and associated consultant professional fee charges, the claiming of radiology and/or pathology benefit will continue on the basis of a fully completed and collated Aviva claim form as completed by the admitting consultant surgeon/physician, which will be submitted by the hospital in conjunction with its own invoice for services provided. However, in **exceptional circumstances** when unforeseen delays occur in the submission of a claim in excess of three months from the date of test/service due to extenuating circumstances, the Consultant Pathologist and/or Radiologist may submit to Aviva Health, a completed claim form which must include side 1 of the form completed and signed by the Aviva member, side 2 of the claim form completed in as far as is possible by an attending Consultant, to comprise clinical data including member Discharge Summary (where available),and all other invoices related to the admission are attached to the claim i.e. Hospital and other Secondary Consultants. This exception may not be availed of, for routine bill submission due to routine or on-going completion delays by either the submitting hospital or the admitting consultant. For a specific Consultant (or Consultant Group) to avail of

this facility they must notify the Claims Manager of Aviva Health explaining the reason for the use of this exception to ensure that issues arising from the use of this exemption are maintained at a minimal level.

20. In-patient Major Medical Illnesses

A Major Medical Illness benefit is payable when it is necessary for a consultant, in non-surgical cases, to give constant attention to an ill patient where one of the illnesses listed on the following pages is the confirmed diagnosis.

This benefit is not payable for claims that involve a surgical procedure or an invasive diagnostic procedure listed in this schedule.

Benefit is payable once only, and only for a single illness listed, per hospital admission and must be specifically claimed.

Major Medical Illness benefit is not payable to the same consultant that receives the ICU/ Neonatal intensive care benefit when the patient is being treated in an intensive care unit or neonatal intensive care unit.

20.1 Diseases of the Respiratory System

8400	Acute severe ventilatory failure (PaO2 less than 8 kPa) occurring as an acute event
8401	Acute pulmonary oedema
8405	Life-threatening broncho-pulmonary haemorrhage
8410	Congenital conditions of the newborn associated with acute continuous respiratory distress
8415	Hyaline membrane disease, ventilation and/or CPAP
8420	Pneumothorax or pneumomediastinum necessitating insertion of underwater seal
8425	Acute airway obstruction by foreign body
8430	Acute bronchiolitis in infants
8432	Severe/acute asthma in a child requiring supplemental oxygen therapy
8433	Acute respiratory failure for patients requiring ventilation assist and management with initiation of pressure or volume preset ventilators for assisted or controlled breathing

20.2 Diseases of the cardiovascular system

8435	Acute myocardial infarction
8437	Life threatening rhythm disturbances
8440	Cardiogenic shock
8445	Acute rheumatic heart disease
8450	Congenital conditions of the newborn associated with cyanosis and heart failure
8455	Hypotensive shock
8460	Hypertensive crisis
8465	Cardiac arrest
8470	Acute bacterial endocarditis (myocarditis or pericarditis)

20.3 Diseases of the Digestive System

8475	Massive gastrointestinal haemorrhage
8480	Acute infantile diarrhoeal disease, causing dehydration and metabolic disturbance
8485	Acute liver failure
8490	Congenital condition of the newborn associated with acute continuous digestive disturbances
8495	Paediatric conditions requiring hyperalimentation
8500	Paediatric necrotising enterocolitis
8501	Intussusception in neonates, diagnosis, resuscitation and medical management prior to referral to a consultant radiologist for closed reduction

20.4 Diseases of the Nervous System

8505	Acute vascular lesions affecting CNS requiring immediate intensive investigation: • Cerebral haemorrhage, embolism, thrombosis, acute with objective neurological signs • Spontaneous subarachnoid haemorrhage
8506	Generalised tonic-clonic seizures with major convulsions occurring in sequence without remission not responsive to bolus therapy
8515	Reye's syndrome

20.5 Diseases of the Genitourinary system

8520	Acute renal failure

20.6 Diseases of the Endocrine System

8525	Diabetic ketoacidosis
8526	Hyperosmolar nonketotic coma (hyperglycemic) in patients with plasma glucose in the range of 55.5mmol/L and calculated serum osmolality in the region of 385 mOsm/kg., on presentation. The average fluid deficit is 10L

20.7 Diseases of the Blood, Lymphatic system

8535	Septicaemia/endotoxic shock
8540	Acute life endangering poisonings requiring high intensity intervention

20.8 Diseases associated with specific cancer diagnosis

8530	Primary blood dyscrasia or lymphoma with acute manifestations
8541	Total marrow failure, acute manifestations arising as a result of a disease process. Not claimable for the management of a patient with marror suppression while on cytotoxic chemotherapy
8560	Paediatric malignancies including leukaemia
8565	Hodgkin's disease
8570	Aggressive non-Hodgkin's lymphomas
8575	Testicular and other germ cell tumours
8580	Sarcomas of bone
8585	Ewing's sarcomas and other small blue round-cell tumours

20.9 Other Reasons

8545	Major trauma, not involving surgery
8550	Other reasons, by report as notified and approved for benefit by Aviva

8551	Complex discharge planning, by a consultant in Palliative Medicine, includes meeting the patients family and healthcare professionals and planning the patients future care needs.
8552	Care provided by a Consultant in Palliative Medicine that requires the intensity of service appropriate in the case of a dying patient in the final days of life
8586	Anorexia Nervosa, severely symptomatic patients with body Weight 75% less than expected whose condition must be stabilised and/or require intensive monitoring for medical problems

NEONATOLOGY AND NEONATAL INTENSIVE CARE

1. Intensive Care Medicine Benefit

Neonatal intensive care benefits are payable to Consultant Neonatologists and Consultant Paediatricians who are registered with Aviva, and who are attached to a Neonatal Intensive Care Unit registered with Aviva and which meets BAPM (British Association of Perinatal Medicine) definition of a level 3 Neonatal Intensive Care Unit.

The benefits relate to the medical management of babies that are so sick or have the likelihood of acute deterioration that they generally require 1:1 care by a nurse with neonatal qualification and are accommodated in the neonatal intensive care facility of a hospital providing 24 hour continuous consultant availability.

Hospitals providing neonatal intensive care must have continuous availability of qualified medical and nursing staff and resources to meet the needs of all babies. Hospitals must be able to demonstrate the necessary professional and technical infrastructure, together with protocols for the care of critically ill babies.

When a baby is admitted under the care of a Consultant Neonatologist or Consultant Paediatrician and requires active medical attention from the admitting consultant physician including the period of the baby's stay in the NICU, the in-patient attendance benefit is payable to the admitting physician in addition to the intensive care benefits payable to the consultant who treats the baby in the neonatal intensive care unit.

2. Intensive Care Unit Approval

An Aviva approved Neonatal Intensive Care Unit (NICU) must be a separate designated hospital facility for the care of critically ill babies. The unit to be a level 3 (in accordance with BAPM) neonatal intensive care categorisation. Each neonatal intensive care unit cot should have available the following:

- incubator or unit with radiant heating;
- ventilator and NCPAP driver with humidifier;
- syringe/infusion pumps;
- facilities for monitoring the following variables:
  (i) respiration
  (ii) heart-rate
  (ii) intra-vascular blood pressure

(iv) transcutaneous or intra-arterial oxygen tension
(v) oxygen saturation
(vi) ambient oxygen

Each neonatal intensive care unit cot should have access to equipment for:

- Resuscitation
- Blood gas analysis (on the neonatal unit by unit staff)
- Phototherapy
- Non-invasive blood pressure measurement
- Transillumination by cold light
- Portable X-rays
- Ultrasound scanning
- Expression of breast milk
- Transport (including mechanical ventilation)
- Instant photographs

There must also be access to 24-hour laboratory service orientated to neonatal service units.

3. Intensive Care Neonatal Medicine Services

Neonatal intensive care benefits are payable for seriously ill babies admitted to an Aviva approved neonatal care intensive unit. The babies will be:

- near-term typically requiring 1 to 3 days mechanical ventilation or
- pre-term typically requiring 1 to 2 weeks mechanical ventilation support or
- extremely pre-term of less than 1,500 grams requiring mechanical ventilation support typically for up to 3 weeks.

These babies have the most complex problems. They generally require 1:1 care by a nurse with a neonatal qualification. The possibility of acute deterioration is such that there should be constant availability of a competent doctor.

4. Eligible infants for Intensive Care Unit Benefit

These include:

(a) receiving any respiratory support via a tracheal tube and in the first 24 hours after its withdrawal
(b) receiving NCPAP for any part of the day and less than five days old
(c) below 1,000g current weight and receiving NCPAP for any part of the day and for 24 hours after withdrawal
(d) less than 29 weeks gestational age and less than 48 hours old
(e) requiring major emergency surgery, for the pre-operative period and post-operatively for 24 hours
(f) requiring complex clinical procedures:
    - Full exchange transfusion

- Peritoneal dialysis
- Infusion of an inotrope, pulmonary vasodilator or prostaglandin and for 24 hours afterwards

(g) any other very unstable baby considered by the nurse-in-charge to generally require 1:1 nursing: for audit, a register should be kept of the clinical details of babies recorded in this category

(h) a baby on the day of death

5. Patient Care in Neonatal Intensive Care Unit

Patient care also includes but is not limited to the following:

- assessment of the patient including blood gases and/or pulmonary function testing
- minute to minute attendance with the patient with frequent reassessment of blood gases/ clinical state and pulmonary function, hereafter frequent review (i.e. several visits by the consultant to the patient during each 24 hour period)
- the support of other organ systems if required
- prescription of appropriate sedative/analgesia regimes – these may include narcotic infusions
- IV drugs
- Vaso-active agents
- Taking blood
- Venous pressure on blood volume studies
- Oximetry
- IV cannulation
- Continuous ECG monitoring
- Nasogastric tube
- Transtracheal aspiration
- Laryngoscopy
- Endotracheal intubation
- Invasive neurological monitoring
- Urinary catheterization
- Interpretation and performance of other tests and procedures as appropriate

6. Clinical Standards in Neonatal Intensive Care Unit

Each unit must comply fully with the following standards in relation to:

- Medical Staff
- Nursing Protocols
- Clinical Protocols
- Quality Assurance
- Training and continuing education

7. Medical Staff in Neonatal Intensive Care Unit

Consultants whose principle duties are to the NICU should staff the unit. The unit must have a Consultant Neonatologist as medical director supported by other suitably qualified Consultants with allocated paediatric intensive care sessions providing 24 hour continuous availability.

8. Nursing Protocols in Neonatal Intensive Care Unit

- All units undertaking neonatal intensive and high-dependency care should be able to demonstrate the required number of appropriately trained and qualified nurses.
- The nursing establishment of a Neonatal Intensive Care Unit should be calculated to ensure that infants receiving intensive care are the sole responsibility of a qualified Neonatal Nurse.
- Units undertaking ant neonatal intensive or high dependency care should have a senior nurse with neonatal experience and managerial responsibility.
- Because of the complexities of care needed for a baby receiving intensive care, there should generally be 1:1 nursing.
- All units should have a designated nurse responsible for further education and training, including in-service experience in resuscitation of babies at birth.
- The need for extra nursing support cannot be predicted so there should always be at least one nurse available on each shift on all units provided intensive and/or high dependency care.
- The nursing establishment for each unit should be sufficient to allow for leave, maternity leave, sickness, study leave, staff training, attendance at multi-disciplinary meetings and professional development, without compromising the principles above.

9. Neonatal Intensive Care Unit Clinical Protocols, Training and Quality Assurance

Each Unit undertaking Neonatal Intensive Care should agreed, written protocols for medical and nursing staff, which also contain details of practical procedures. These must be regularly reviewed through discussion and audit.

There should be a protocol for the resuscitation and management of extremely pre-term infants. There should be monitoring systems for short and longer term morbidity among survivors with plans for regular review, including protocols for:

- Cerebral ultrasound examination
- Screening and treatment for retinopathy of prematurity
- Screening for hearing loss

All new members of staff should undergo a period of introduction, orientation and training. All hospitals providing Neonatal Intensive Care should have a regular continuing programme of in-service training including neonatal resuscitation. Nurses and doctors involved in Neonatal Intensive Care should be able to demonstrate continuing professional development in the specialty by attendance at regular multi-disciplinary meetings with midwives; obstetricians and pathologists to monitor mortality and morbidity, local meetings, suitable training courses and national meetings.

The unit should use a data collection system to monitor workload and the results of practice. Each unit should have a written policy in relation to an established strategy for clinical governance, maintenance, replacement and upgrading of equipment for neonatal care, which comply with national standards, including and audit programme and critical incident reporting. Clinical audit must be a component of Neonatal Intensive Care Medicine Service and the anonymised data should be available to Aviva on an annual basis.

Training and Continuing Professional Development

10. Consultation Benefit for Neonatology Intensive Care Unit

Consultation benefit is payable to the Consultant Neonatologist, or to a designated Consultant Paediatrician attached to an Aviva approved Neonatal Intensive Care Unit, for a patient being assessed for admission to the Neonatal Intensive Care Unit as defined in the ground rules for Neonatal Intensive Care, Ground rule 2 and where it is deemed that the patient does not require admission to the neonatal intensive care unit.

Code	Description
8694	Consultant Neonatologist or Paediatrician In-Patient Consultation

Note: Individual benefits in accordance with the Schedule of Benefits for Professional Fees are not payable for procedures which are listed under Neonatal Intensive Care Ground rule 2 except those listed below

11. Other procedures for which additional benefit is payable

The following procedures are payable in addition to the NICU Medicine benefit where the service is provided during the baby's stay in the NICU unit.

Code	Description
5091	Cardioversion
5089	Echocardiography, Transoesophageal
5962	Insertion of tube drain into pleural cavity
5251	Closed drainage of pneumothorax

Note: benefit for the above procedures is payable once only during the baby's stay in the neonatal intensive care unit.

12. Major Consultation Benefit for Inpatient Neonatologist or Paediatrician Consultation

A major inpatient consultation benefit is payable to the Consultant Neonatologist, or to a Consultant Paediatrician who provided consultation and care over several days on the post natal ward to a new-born with the following problems:

- An infant having septic workups and receiving IV antibiotics on the post natal ward for up to 48 hours post birth

- An infant requiring referral to another specialist after delivery for congenital malformations or chromosomal abnormalities
- An infant <2.5 kg both weight and/ or <37 weeks of completed gestation

This fee is paid on the basis that the Consultant Neonatologist or Consultant Paediatrician is required to travel to the hospital, at the request of the hospital staff for the evaluation of the neonate (as set out above) between 18.00 and 08.00. Benefit is limited to one fee per patient per episode of care and will not be payable where its coincides with the consultants normal time for meeting patients or family or for consultant personal choice or availability.

Code	Description
8694	Consultant Neonatologist or Paediatrician Major In-Patient Consultation

PERIODONTAL / ORAL / DENTAL SURGERY

1. General Dental Practitioner

1.1. Benefit is payable to General Dental practitioners, only at the standard rate.

1.2. The range of procedures to be covered as per the attached schedule.

1.3. For Dental Surgeons to be registered with Aviva Health:

1.3.1. They must be on the Irish Dental Council register.

1.3.2. The performance of a procedure by a Dental Surgeon under General Anaesthesia or Sedation will not be covered by Aviva Health.

1.3.3. Where Local Anaesthetic is performed it will only be eligible for cover where it is performed in a listed Aviva fully participating Hospital, and the relevant listed Aviva professional fee only at the standard rate will be paid (list below).

2. Oral Surgeon

2.1. Have the option of participating with Aviva Health for treatment of our members on either fully participating or part participating basis.

2.2. The range of procedures to be covered as per the attached schedule.

2.3. For Oral Surgeons to be registered with Aviva Health:

2.3.1. They must be on the Irish Dental Council specialist register of Oral surgeons.

2.3.2. Must indicate for the entire year if they are fully or part participating.

2.3.3. Must supply a copy of the above registration annually to Aviva Health.

2.3.4. Where a General Anaesthetic is required it will be liable for cover when performed in a listed Aviva fully participating Hospital, under the supervision of a Consultant Anaesthetist who is fully participating with Aviva and on the Specialist register of the Irish Medical Council. These procedures will be graded as and payable as day cases and are listed below.

2.3.5. Where sedation is given to an Aviva member, this may only be administered in an Aviva participating hospital, or in the private practice of an Oral Surgeon on the Register of Oral Surgeons as maintained by the Dental Council.

2.3.6. Where Local Anaesthetic is performed it will only be eligible for cover where administered in an Aviva participating hospital or in the private practice of an Oral Surgeon on the Register of Oral Surgeons as maintained by the Dental Council and the relevant listed Aviva professional fee only will be paid.

Where an Oral surgeon elects to be registered with Aviva as fully participating, then such fee payable at the fully participating rate for the performance of the

procedure(s) covered by this Schedule of Benefits for Professional Fees, will be regarded as the total fee payable to the Oral Surgeon for the performance (both professional fee and any technical or facility fee) for the procedure(s). Where such a procedure is performed in an Aviva approved hospital, then the agreed hospital fee shall also be paid to the hospital concerned.

3. Periodontist

3.1. Have the option of participating with Aviva Health for treatment of our members on either fully participating or part participating basis.

3.2. The range of procedures to be covered as per the attached schedule.

3.3. For Periodontists to be registered with Aviva Health:

3.3.1. They must be on a list of Periodontists (pending a legislative framework) as maintained by Aviva

3.3.2. To be eligible to be on the Aviva list above, the Periodontist must have completed a 3 year post graduate training course in a recognised training facility such that the qualification is recognised or at least equivalent to training courses accredited by the European Federation of Periodontists

3.3.3. Must indicate for the entire year if they are fully or part participating.

3.3.4. Must supply a copy of the above registration annually to Aviva Health

3.3.5. Where a General Anaesthetic is required it will be liable for cover when performed in a listed Aviva fully participating Hospital, under the supervision of a Consultant Anaesthetist who is fully participating with Aviva and on the Specialist register of the Irish Medical Council. These procedures will be graded as and payable as day cases and are listed below.

3.3.6. Where sedation is given to an Aviva member, this may only be administered in an Aviva participating hospital, or in the private practice of the Periodontist as registered above.

3.3.7. Where Local Anaesthetic is performed it will only be eligible for cover where administered in an Aviva participating hospital or in the private practice of Periodontist as registered aboveand the relevant listed Aviva professional fee only will be paid.

3.3.8. Where an Periodontist elects to be registered with Aviva as fully participating, then such fee payable at the fully participating rate for the performance of the procedure(s) covered by this Schedule of Benefits for Professional Fees, will be regarded as the total fee payable to the Periodontist for the performance (both professional fee and any technical or facility fee) for the procedure(s). Where such a procedure is performed in an Aviva approved hospital, then the agreed hospital fee shall also be paid to the hospital concerned.

Dental Surgeon Procedures – Local Anaesthesia	
12973	Removal of one upper impacted or unerupted tooth
12974	Removal of two upper impacted or unerupted teeth
12976	Removal of one lower impacted or unerupted tooth
12977	Removal of two lower impacted or unerupted teeth

Oral Surgeon Procedures - General Anaesthesia	
1046	Excision of lesion of mucosa and submucosa, vestibule of mouth, with simple repair (I.P.)
1047	Excision of lesion of mucosa and submucosa, vestibule of mouth, complex, with or without excision of underlying muscle (I.P.)
2930	Buried tooth roots, (includes more than one root) of one tooth, removal of
2935	Buried tooth roots, (multiple) of teeth, removal of.
2940	Dental cysts of maxilla or mandible
2950	Extraction of teeth (more than six permanent teeth) with or without alveolectomy
2973	Removal of one upper impacted or unerupted tooth
2974	Removal of two upper impacted or unerupted teeth
2976	Removal of one lower impacted or unerupted tooth
2977	Removal of two lower impacted or unerupted teeth
2978	Removal of one impacted or unerupted canine tooth
2979	Removal of two impacted or unerupted canine teeth
2980	Labial frenectomy with dissection of tissue
2981	Removal of four or more impacted or unerupted teeth
2982	Removal of three impacted or unerupted teeth which includes two lower teeth
2983	Removal of three impacted or unerupted teeth which includes two upper teeth
2984	Removal of one upper and one lower impacted or unerupted tooth
2985	Odontoma, excision of
3001	Surgical exposure and repositioning of an impacted tooth
3002	Surgical exposure and repositioning of impacted teeth
3015	Reimplantation of tooth in socket with splinting

Oral Surgeon Procedures - General Anaesthesia	
3020	Simple cysts or epulis, palate or floor of mouth, excision of
3001	Surgical exposure and repositioning of an impacted tooth
3002	Surgical exposure and repositioning of impacted teeth
3005	Root resection or apicectomy, single, with or without cyst removal and apical curettage
3010	Root resection or apicectomy, multiple, with or without cyst removal and apical curettage
3015	Reimplantation of tooth in socket with splinting
3020	Simple cysts or epulis, palate or floor of mouth, excision of
3025	Small tumours of dental origin, removal of, includes biopsy

Periodontal Procedures - General Anaesthesia	
2930	Buried tooth roots, (includes more than one root) of one tooth, removal of
2935	Buried tooth roots, (multiple) of teeth, removal of
2940	Dental cysts of maxilla or mandible
2950	Extraction of teeth (more than six permanent teeth) with or without alveolectomy
2953	Gingivectomy, one to four teeth
2954	Gingivectomy, five to eleven teeth
2956	Gingivectomy, twelve or more teeth
2973	Removal of one upper impacted or unerupted tooth
2974	Removal of two upper impacted or unerupted teeth
2976	Removal of one lower impacted or unerupted tooth
2977	Removal of two lower impacted or unerupted teeth
2978	Removal of one impacted or unerupted canine tooth
2979	Removal of two impacted or unerupted canine teeth
2980	Labial frenectomy with dissection of tissue
2981	Removal of four or more impacted or unerupted teeth
2982	Removal of three impacted or unerupted teeth which includes two lower teeth

Periodontal Procedures - General Anaesthesia	
2983	Removal of three impacted or unerupted teeth which includes two upper teeth
2984	Removal of one upper and one lower impacted or unerupted tooth
2985	Odontoma, excision of
2996	Periodontal mucoperiosteal flap surgery, one to four teeth
2997	Periodontal mucoperiosteal flap surgery, five to eleven teeth
2998	Periodontal mucoperiosteal flap surgery, twelve or more teeth
3001	Surgical exposure and repositioning of an impacted tooth
3002	Surgical exposure and repositioning of impacted teeth
3005	Root resection or apicectomy, single, with or without cyst removal and apical curettage
3010	Root resection or apicectomy, multiple, with or without cyst removal and apical curettage
3015	Reimplantation of tooth in socket with splinting
3020	Simple cysts or epulis, palate or floor of mouth, excision of
3025	Small tumours of dental origin, removal of, includes biopsy

PAEDIATRIC MEDICAL DAY CARE MEDICINE

1. Definition

Benefit is payable when a child, under sixteen years of age (or up to eighteen years of age where the patient has been attending the consultant on an on-going basis for the condition since childhood), receives medical treatment from a consultant paediatrician for the procedures/ investigations listed below which are deemed appropriate by Aviva for day care admission in a Aviva approved hospital, which is specifically equipped and staffed for such cases.

2. Benefit Payable

The benefit payable to the consultant paediatrician will be payable at the same rates as apply to In-Patient treatment, e.g. for a patient attending for one day care session.

This benefit will be paid only where the consultant paediatrician takes personal responsibility for the patient and provides medical services during the hospital stay including the initiation of relevant testing and where appropriate to covey results to the appropriate representative of the patient. Where the investigation is carried out by a technician or other paramedic, and the patient is not treated by the consultant paediatrician during the hospital stay, professional fee benefit will not be paid.

In addition, benefit is payable for Consultant Radiologists and Pathologists services incurred during the admission.

Code	Description
10000	Medical Management for specific Paediatric Medical Day Care Procedures/investigations

3. Medical Procedures Approved for Paediatric Day Care Admission:

The following list of medical procedures in paediatric cases are payable for day care admission:

- DTPA scans, DMSA scans, and chromium EDTA
- Investigations for hypoglycaemia and other metabolic disorders that involve prolonged fasting and ongoing monitoring
- Glucose tolerance test
- Growth Hormone Stimulation Tests
- Food allergy challenge requiring consultant supervision and decision making
- Prolonged LHRH and TRH testing
- CT Scanning involving cannulation and Sedation
- MRI Scanning requiring cannulation and Sedation
- Invasive Cardiac Assessments
- Micturating Cystogram requiring Sedation and Catheterisation
- Administration of MMR in individuals with histories of anaphylactic hypersensitivity to hen's eggs when diagnosis has been confirmed by appropriate testing and expert review.
- Administration of any vaccine type to a child that had an adverse reaction to a previous vaccine or in a child with an inborn error of metabolism.
- Consultant multi disciplinary team review of a severely disabled child with complex medical problems.

For Bone Marrow Aspiration, IV Transfusion Therapies (including Immunoglobulin Transfusion and Chemotherapy administration) and Lumbar Puncture please refer to the relevant procedure code.

All of the above procedures/investigations must involve a minimum of three hours occupation of a bed. The times of admission and discharge must be recorded on the claim form.

4. Conditions of payment:

The claiming of benefit will continue on the basis of a fully completed Aviva claim form from the primary treating consultant.

RADIOTHERAPIST SERVICES

1. In-Patient

Consultant physician benefit will be paid on the basis of the In-Patient Attendance Benefit rates.

2. Day Care

Consultant physician benefit for day care radiotherapy will be payable at the same benefit rates as apply to In-Patient Attendance.

If it is medically necessary for the patient to have repeat day care stays for radiotherapy, benefit will be payable to the consultant at the same rate as if the patient had been an in-patient. For multiple day care radiotherapy the attending consultant's benefit is calculated at the end of the course of radiotherapy treatment.

Day care radiotherapy is only payable when it is medically necessary for a patient be admitted to a day care facility. It is expected that most ambulatory patients in need of radiotherapy, will be treated on an ambulatory day care basis.

These services include, clinical treatment planning, manual design, simulation, computer assisted simulation, tumour localisation, treatment volume determination, treatment time/dosage determination, choice of treatment modality, determination of number and size of treatment ports, selection of treatment devices and other procedures, consultations and assessments of the patient throughout the course of radiotherapy treatment, psychological support for the patient and family (if necessary).

The benefits also include one follow up outpatient consultation after the course of radiotherapy treatment has been completed.

3. Conditions of payment

The claiming of radiolotherapy benefit will be on the basis of a fully completed Aviva Health claim form, from the admitting surgeon/physician. However, in exceptional circumstances when unforeseen delays occur in the submission of a claim in excess of three months from the date of test/service, the consultant radiologist may submit, to Aviva Health, a fully completed claim form duly signed by the Aviva Health member, in conjunction with the hospital / treatment centre invoice for that episode of care.

Note:
*Consultant ***day care** radiation oncology comprehensive benefit services including (but not limited to):*

- *clinical treatment planning*
- *manual design*
- *simulation*
- *tumour localisation*
- *treatment volume determination*
- *treatment time/dosage determination*
- *choice of treatment modality*
- *determination of number and size of treatment ports*
- *selection of treatment devices and other procedures*
- *Departmental clinical responsibility*
- *Consultations and assessments of the patient throughout the course of radiotherapy treatment; psychological support for the patient and family (if required)*

The benefits listed in the Radiotherapy benefits section of the Schedule are inclusive of all forms of imaging guidance evaluation throughout the radiotherapy sessions, except as otherwise stated.

***The benefit also incorporates one follow-up out-patient consultation** after the course of radiotherapy treatment has been completed.*

The benefit levels are site specific. However, if the site listing is not shown below then please report under codes 5643 to 5656. Full details of the site(s) involved should be documented on the claim form.

**It is expected that most ambulatory patients in need of radiotherapy will be treated on a day care basis. The in-patient attendance rates apply to patients who are admitted to hospital for external beam treatment.*

INTERSTITIAL BRACHYTHERAPY (MULTIPLE)
Note this includes the generation of complex computerised plan or CT planning with homogeneity criteria assessment/minimum/maximum point assessment and brachytherapy treatment, removal of needles when course is completed. All-inclusive benefit for multiple fractions including one follow-up out-patient consultation after the course of treatment has been completed.

GENERAL SURGICAL PROCEDURE CODES & RATES

Code	Description	Payment Rules	Payment Indicators	Speciality
5	Abdominal wall, secondary suture of			General Surgical - Abdominal Wall & Peritoneum
15	Adhesions division of by laparotomy or laparoscopy		(I.P.)	General Surgical - Abdominal Wall & Peritoneum
20	Intra abdominal injury with rupture of viscus (I.P.)		(I.P.)	General Surgical - Abdominal Wall & Peritoneum
25	Intra abdominal injury, multiple complicated with rupture of viscus (I.P.)		(I.P.)	General Surgical - Abdominal Wall & Peritoneum
30	Laparotomy (I.P.)		(I.P.)	General Surgical - Abdominal Wall & Peritoneum
35	Laparoscopy with or without biopsy (I.P.)		(I.P.)	General Surgical - Abdominal Wall & Peritoneum
45	Omentopexy			General Surgical - Abdominal Wall & Peritoneum
50	Paracentesis abdominis			General Surgical - Abdominal Wall & Peritoneum
55	Paracentesis abdominis with infusion of cytotoxic drugs	See note below		Skin & Subcutaneous Tissues
For infusion procedures 55, 167, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, codes may only be claimed when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given.				
60	Pelvic abscess, drainage of			General Surgical - Abdominal Wall & Peritoneum
80	Peritoneum, drainage of (I.P.)		(I.P.)	General Surgical - Abdominal Wall & Peritoneum
90	Laparotomy, intra-abdominal sepsis (I.P.)		(I.P.)	General Surgical - Abdominal Wall & Peritoneum

Code	Description	Payment Rules	Payment Indicators	Speciality
95	Adrenalectomy, unilateral (I.P.)		(I.P.)	General Surgical - Adrenal Glands
101	Adrenalectomy for phaeochromocytoma			General Surgical - Adrenal Glands
102	Laparoscopy, comma surgical with adrenalectomy, partial or complete or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal			General Surgical - Adrenal Glands
106	Neuroblastoma, tru-cut biopsy		Diagnostic	General Surgical - Adrenal Glands
107	Neuroblastoma, resection			General Surgical - Adrenal Glands
110	Appendicectomy (with or without complications) (I.P.)		(I.P.)	General Surgical - Appendix
111	Appendicectomy, laparoscopic approach (with or without complications) (I.P.)		(I.P.)	General Surgical - Appendix
115	Cholecystojejunostomy			General Surgical - Gall Bladder & Bile Ducts
116	Choledochojejunostomy (Roux - En - Y)			General Surgical - Gall Bladder & Bile Ducts
117	Choledochoduodenostomy			General Surgical - Gall Bladder & Bile Ducts
118	Surgical repair of post-operative biliary stricture			General Surgical - Gall Bladder & Bile Ducts
129	Hepaticojejunostomy			General Surgical - Gall Bladder & Bile Ducts
132	Cholecystectomy with exploration of common bile duct			General Surgical - Gall Bladder & Bile Ducts
134	Laparoscopic cholecystectomy including per-operative cholangiogram			General Surgical - Gall Bladder & Bile Ducts
135	Cholecystectomy including per operative cholangiogram			General Surgical - Gall Bladder & Bile Ducts
136	Percutaneous removal of gallstones from the bile ducts			General Surgical - Gall Bladder & Bile Ducts
140	Cholecystostomy with exploration, drainage or removal of calculus			General Surgical - Gall Bladder & Bile Ducts
145	Hepaticoduodenostomy			General Surgical - Gall Bladder & Bile Ducts
150	Transduodenal sphincteroplasty with or without transduodenal extraction of calculus			General Surgical - Gall Bladder & Bile Ducts
151	Transhepatic insertion of biliary endoprosthesis or catheter for biliary drainage			General Surgical - Gall Bladder & Bile Ducts

Code	Description	Payment Rules	Payment Indicators	Speciality
152	Percutaneous insertion of gall bladder catheter for MTBE installation including catheter removal			General Surgical - Gall Bladder & Bile Ducts
153	Insertion of naso-biliary tube and administration of CDC/URSO			General Surgical - Gall Bladder & Bile Ducts
154	Change of percutaneous biliary drainage catheter	Monitored Anaesthesia Benefit Only		General Surgical - Gall Bladder & Bile Ducts
155	Antrectomy and drainage			General Surgical - Gastric
156	Revision and/or reinsertion of transhepatic tube (IP)		(I.P.)	General Surgical - Gall Bladder & Bile Ducts
165	Duodenal diverticula, excision of			General Surgical - Gastric
174	Wedge gastric excision for ulcer or tumour of stomach			General Surgical - Gastric
175	Gastrectomy, total or revision with anastomosis, pouch formation / reconstruction/Roux-en-Y reconstruction			General Surgical - Gastric
178	Gastric restrictive procedure with gastric by-pass for morbid obesity with Roux-En-Y gastroenterostomy (IP). **Pre-authorisation required**	See note below		General Surgical - Gastric

We will provide benefit for bariatric surgery for severe morbid obesity in accordance with the following conditions of payment set out below and only once in a lifetime. Benefit is restricted to those patients whose BMI are indicated as below in no.1 and who satisfy all of the criteria's No.'s 2-8. Conditions of payment for procedures 178,179,181 and 182 are as follows 1. Benefit for laparoscopic banding 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 and who have also been diagnosed with any of the following severe co-morbidities: Coronary Heart Disease: Type 2 Diabetes : Clinically significant obstructive sleep apnoea or : Medically refractive hypertension (blood pressure greater than 140mmHg systolic and/or 90mmHg diastolic despite optimal medical management. BMI more than50 kg/m2 in whim surgical intervention is considered appropriate 2. Bariatric surgery is only payable in hospitals listed in the Aviva Healthcare directory of Hospitals and where Aviva has approved the multi-disciplinary programme for the treatment of obesity. The multi disciplinary team must consist of a Consultant recognised by Aviva who has a special interest in the management of obesity, specialist nurses and a Dietician. Patients that are seeking bariatric surgery for severe obesity must have received management in a non-surgical obesity 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. Documentation to support this must be provided by the supervising consultant. 3. Gastric restrictive or bypass procedures will only be eligible for benefit for well informed and motivated members with acceptable operative risks. Individuals must be 18yrs or over. 4. Evidence must be provided that all appropriate and available non-surgical measures have been adequately tried but the member has failed to maintain weight loss. 5. Patients who are candidates for surgical procedures must be evaluated by a multi-disciplinary team with a medical surgical, psychological and nutritional experience. 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 Aviva. Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up. 6. The operation should be performed by a Consultant Surgeon with experience in bariatric surgery registered with Aviva who is substantially experienced with the appropriate procedures working in the multi disciplinary programme in a clinical setting with adequate support for all aspects of management and assessment. 7. In addition arrangements should be made for appropriate healthcare professionals to provide pre-operative and post-operative counselling and support to patients being considered for surgery. Each patient therefore must have access to a specialist team consisting of a Dietician, a physiotherapist and a dedicated nurse (ideally a specialist gastric surgery nurse). Each team should also include a physician with a special interest in obesity to assess the patient for surgery, a consultant surgeon with a special interest in bariatric surgery, a consultant anaesthetist and where appropriate a consultant radiologist. 8. Life long medical surveillance after surgical therapy is a necessity.

Code	Description	Payment Rules	Payment Indicators	Speciality
179	Gastric restrictive procedure, with partial gastrectomy, pylorus preserving duodenileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption/ biliopancreatic diversion with duodenal switch **Pre-authorisation required**	See note below		General Surgical - Gastric
We will provide benefit for bariatric surgery for severe morbid obesity in accordance with the following conditions of payment set out below and only once in a lifetime. Benefit is restricted to those patients whose BMI are indicated as below in no.1 and who satisfy all of the criteria's No.'s 2-8. Conditions of payment for procedures 178,179,181 and 182 are as follows 1. Benefit for laparoscopic banding is restricted to those patients whose BMI is currently and has been for at least 2 years greater than 4 and less than or equal to 5 and who have also been diagnosed with any of the following severe co-morbidities: Coronary Heart Disease: Type 2 Diabetes : Clinically significant obstructive sleep apnoea or : Medically refractive hypertension (blood pressure greater than 14mmHg systolic and/or 9mmHg diastolic despite optimal medical management. BMI more than5 kg/m2 in whom surgical intervention is considered appropriate 2. Bariatric surgery is only payable in hospitals listed in the Aviva Healthcare directory of Hospitals and where Aviva has approved the multi-disciplinary programme for the treatment of obesity. The multi disciplinary team must consist of a Consultant recognised by Aviva who has a special interest in the management of obesity, specialist nurses and a Dietician. Patients that are seeking bariatric surgery for severe obesity must have received management in a non-surgical obesity 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. Documentation to support this must be provided by the supervising consultant. 3. Gastric restrictive or bypass procedures will only be eligible for benefit for well informed and motivated members with acceptable operative risks. Individuals must be 18yrs or over. 4. Evidence must be provided that all appropriate and available non-surgical measures have been adequately tried but the member has failed to maintain weight loss. 5. Patients who are candidates for surgical procedures must be evaluated by a multi-disciplinary team with a medical surgical, psychological and nutritional experience. 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 Aviva. Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up. 6. The operation should be performed by a Consultant Surgeon with experience in bariatric surgery registered with Aviva who is substantially experienced with the appropriate procedures working in the multi disciplinary programme in a clinical setting with adequate support for all aspects of management and assessment. 7. In addition arrangements should be made for appropriate healthcare professionals to provide pre-operative and post-operative counselling and support to patients being considered for surgery. Each patient therefore must have access to a specialist team consisting of a Dietician, a physiotherapist and a dedicated nurse (ideally a specialist gastric surgery nurse). Each team should also include a physician with a special interest in obesity to assess the patient for surgery, a consultant surgeon with a special interest in bariatric surgery, a consultant anaesthetist and where appropriate a consultant radiologist. 8. Life long medical surveillance after surgical therapy is a necessity.				
180	Gastrectomy, partial with anastomosis, pouch formation/ reconstruction/Rous-en-Y reconstruction	Not Claimable for Morbid Obesity		General Surgical - Gastric

Code	Description	Payment Rules	Payment Indicators	Speciality
181	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (I.P.) **Pre-authorisation required**	See note below		General Surgical - Gastric

We will provide benefit for bariatric surgery for severe morbid obesity in accordance with the following conditions of payment set out below and only once in a lifetime. Benefit is restricted to those patients whose BMI are indicated as below in no.1 and who satisfy all of the criteria's No.'s 2-8. Conditions of payment for procedures 178,179,181 and 182 are as follows 1. Benefit for laparoscopic banding 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 and who have also been diagnosed with any of the following severe co-morbidities: Coronary Heart Disease: Type 2 Diabetes : Clinically significant obstructive sleep apnoea or : Medically refractive hypertension (blood pressure greater than 140mmHg systolic and/or 90mmHg diastolic despite optimal medical management. BMI more than50 kg/m2 in whom surgical intervention is considered appropriate2. Bariatric surgery is only payable in hospitals listed in the Aviva Healthcare directory of Hospitals and where Aviva has approved the multi-disciplinary programme for the treatment of obesity. The multi disciplinary team must consist of a Consultant recognised by Aviva who has a special interest in the management of obesity, specialist nurses and a Dietician. Patients that are seeking bariatric surgery for severe obesity must have received management in a non-surgical obesity 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. Documentation to support this must be provided by the supervising consultant. 3. Gastric restrictive or bypass procedures will only be eligible for benefit for well informed and motivated members with acceptable operative risks. Individuals must be 18yrs or over. 4. Evidence must be provided that all appropriate and available non-surgical measures have been adequately tried but the member has failed to maintain weight loss. 5. Patients who are candidates for surgical procedures must be evaluated by a multi-disciplinary team with a medical surgical, psychological and nutritional experience. 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 Aviva. Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up. 6. The operation should be performed by a Consultant Surgeon with experience in bariatric surgery registered with Aviva who is substantially experienced with the appropriate procedures working in the multi disciplinary programme in a clinical setting with adequate support for all aspects of management and assessment. 7. In addition arrangements should be made for appropriate healthcare professionals to provide pre-operative and post-operative counselling and support to patients being considered for surgery. Each patient therefore must have access to a specialist team consisting of a Dietician, a physiotherapist and a dedicated nurse (ideally a specialist gastric surgery nurse). Each team should also include a physician with a special interest in obesity to assess the patient for surgery, a consultant surgeon with a special interest in bariatric surgery, a consultant anaesthetist and where appropriate a consultant radiologist. 8. Life long medical surveillance after surgical therapy is a necessity. Note while Consultants fees are covered (subject to participation status) hospital fees are only covered as specific Aviva approved hospital sites

Code	Description	Payment Rules	Payment Indicators	Speciality
182	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) **Pre-authorisation required**	See note below		General Surgical - Gastric

We will provide benefit for bariatric surgery for severe morbid obesity in accordance with the following conditions of payment set out below and only once in a lifetime. Benefit is restricted to those patients whose BMI are indicated as below in no.1 and who satisfy all of the criteria's No.'s 2-8. Conditions of payment for procedures 178,179,181 and 182 are as follows 1. Benefit for laparoscopic banding is restricted to those patients whose BMI is currently and has been for at least 2 years greater than 4 and less than or equal to 5 and who have also been diagnosed with any of the following severe co-morbidities: Coronary Heart Disease: Type 2 Diabetes : Clinically significant obstructive sleep apnoea or : Medically refractive hypertension (blood pressure greater than 14mmHg systolic and/or 9mmHg diastolic despite optimal medical management. BMI more than 5 kg/m2 in whom surgical intervention is considered appropriate 2. Bariatric surgery is only payable in hospitals listed in the Aviva Healthcare directory of Hospitals and where Aviva has approved the multi-disciplinary programme for the treatment of obesity. The multi disciplinary team must consist of a Consultant recognised by Aviva who has a special interest in the management of obesity, specialist nurses and a Dietician. Patients that are seeking bariatric surgery for severe obesity must have received management in a non-surgical obesity 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. Documentation to support this must be provided by the supervising consultant. 3. Gastric restrictive or bypass procedures will only be eligible for benefit for well informed and motivated members with acceptable operative risks. Individuals must be 18yrs or over. 4. Evidence must be provided that all appropriate and available non-surgical measures have been adequately tried but the member has failed to maintain weight loss. 5. Patients who are candidates for surgical procedures must be evaluated by a multi-disciplinary team with a medical surgical, psychological and nutritional experience. 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 Aviva. Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up. 6. The operation should be performed by a Consultant Surgeon with experience in bariatric surgery registered with Aviva who is substantially experienced with the appropriate procedures working in the multi disciplinary programme in a clinical setting with adequate support for all aspects of management and assessment. 7. In addition arrangements should be made for appropriate healthcare professionals to provide pre-operative and post-operative counselling and support to patients being considered for surgery. Each patient therefore must have access to a specialist team consisting of a Dietician, a physiotherapist and a dedicated nurse (ideally a specialist gastric surgery nurse). Each team should also include a physician with a special interest in obesity to assess the patient for surgery, a consultant surgeon with a special interest in bariatric surgery, a consultant anaesthetist and where appropriate a consultant radiologist. 8. Life long medical surveillance after surgical therapy is a necessity. Note while Consultants fees are covered (subject to participation status) hospital fees are only covered as specific Aviva approved hospital sites

Code	Description	Payment Rules	Payment Indicators	Speciality
183	Laparoscopy, Gastric Sleeve procedure benefits include all subsequent restrictive device adjustment(s)	See note below		General Surgical - Gastric
Aviva will provide benefit for bariatric surgery for severe morbid obesity in accordance with the following conditions of payment set out below and only once in a lifetime. Benefit is restricted to those patients whose BMI are indicated as below in no.1 and who satisfy all of the criteria's No.'s 2-8. Conditions of payment for procedures 178,179,181 and 182 are as follows 1. Benefit for laparoscopic banding 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 and who have also been diagnosed with any of the following severe co-morbidities: Coronary Heart Disease: Type 2 Diabetes : Clinically significant obstructive sleep apnoea or : Medically refractive hypertension (blood pressure greater than 140mmHg systolic and/or 90mmHg diastolic despite optimal medical management. BMI more than 50 kg/m2 in whom surgical intervention is considered appropriate 2. Bariatric surgery is only payable in hospitals listed in the Aviva Healthcare directory of Hospitals and where Aviva has approved the multi-disciplinary programme for the treatment of obesity. The multi disciplinary team must consist of a Consultant recognised by Aviva who has a special interest in the management of obesity, specialist nurses and a Dietician. Patients that are seeking bariatric surgery for severe obesity must have received management in a non-surgical obesity 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. Documentation to support this must be provided by the supervising consultant. 3. Gastric restrictive or bypass procedures will only be eligible for benefit for well informed and motivated members with acceptable operative risks. Individuals must be 18yrs or over. 4. Evidence must be provided that all appropriate and available non-surgical measures have been adequately tried but the member has failed to maintain weight loss. 5. Patients who are candidates for surgical procedures must be evaluated by a multi-disciplinary team with a medical surgical, psychological and nutritional experience. 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 Aviva. Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up. 6. The operation should be performed by a Consultant Surgeon with experience in bariatric surgery registered with Aviva who is substantially experienced with the appropriate procedures working in the multi disciplinary programme in a clinical setting with adequate support for all aspects of management and assessment. 7. In addition arrangements should be made for appropriate healthcare professionals to provide pre-operative and post-operative counselling and support to patients being considered for surgery. Each patient therefore must have access to a specialist team consisting of a Dietician, a physiotherapist and a dedicated nurse (ideally a specialist gastric surgery nurse). Each team should also include a physician with a special interest in obesity to assess the patient for surgery, a consultant surgeon with a special interest in bariatric surgery, a consultant anaesthetist and where appropriate a consultant radiologist. 8. Life long medical surveillance after surgical therapy is a necessity. Note while Consultants fees are covered (subject to participation status) hospital fees are only covered as specific Aviva approved hospital sites				
190	Gastroenterostomy			General Surgical - Gastric
191	General anaesthesia for gastroscopy and colonoscopy procedures in children under 16 years of age			General Surgical - Gastric

Code	Description	Payment Rules	Payment Indicators	Speciality
192	Capsule Endoscopy	See note below	See note on rule change	General Surgical - Gastric
Conditions for payment of Benefit, in accordance with the Ground Rules, will be payable for an Upper GI Endoscopy (excludes repeat procedures within 12 month, where specific clinical indicators apply). Please note the clinical indicators below are subject to change in the last quarter of 2012. **Initial** 1. Upper abdominal symptoms that persist in a patient that has been tested and received treatment for helicobacter pylori and/or been treated with a trial of PPI's for an appropriate time period. 2. Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease or in patients > 45 years. 3. Dysphagia or odynophygia. 4. oesophageal reflux symptoms that are persistent and recurring. 5. Persistent vomiting of unknown cause. 6. Biopsy for suspect coeliac disease. 7. Other diseases in which the presence of upper GI pathologic conditions might modify other planned management of the patient. 8. Familial adenomatous polyposis syndromes 9. for confirmation and specific histologic diagnosis of radiological demonstrated lesions - suspected neoplastic lesion, gastric ulcer, oesophageal ulcer, upper tract stricture or obstruction10. in patients with active or recent GI bleeding or for GO bleeding for presumed chronic blood loss and for iron deficiency anaemia when the clinical situation suggests an upper GI source or if colonoscopy results are negative. 11. In patients with suspect portal hypertension to document or treat oesophageal varices 12. to assess acute injury after caustic ingestions 13. Treatment of bleeding lesions such as ulcers, tumours, vascular abnormalities 14. banding or sclwerotherapy of oesophageal varices 15. removal of foreign bodies 17. Dilatation of stenotic lesions 18. Management of achalasia 19. Palliative treatment of stenosing neoplasms. **Repeat** No consultant or hospital benefits are payable for repeat GI endoscopy within 12 months of the initial examination except for the following clinical indications: - 1. Histological diagnosis of Gastric ulcer. 2. Coeliac disease - recheck for 3 month healing - one only check 3. Achalasia 4. post banding of oesophageal varices 5. Stent blockage 6. Re-biopsy of an oesophageal ulcer 7. Barrett's mucosa with dysplasia 8. Gastric mucosa showing dysplasia 9. a new clinical indication unrelated to the original endoscopy, which is/are and identified indication, will not be excluded by a prior endoscopy. Code 194 is not claimable with codes 198 or 202				
194	Upper G.I. endoscopy with or without biopsies (includes jejunal biopsy), with or without polypectomy.	Please refer to note after code 192	See note on rule change	General Surgical - Gastric
198	Upper gastrointesinal endoscopy including oesophagus, stomach and either the duodenum and/or jenjunum as appropriate, with endoscopic ultrasound (IP)	See note below		General Surgical - Gastric
1) Oesophageal Cancer - Pre-operative staging and assessment of the respectability in operable patients without distant metastases, especially when stage dependent treatment protocols are applied 2) 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) 3) Gastric; (a) Gastrointestinal sub mucosal tumours to differentiate from extra luminal compression and to plan therapy (resection or follow-up) (b) For diagnosis of gastric malt lymphoma 4) Biliary tumours - Pre-operative staging and distal bile duct tumours 5) Benign conditions of the biliary tract; (a) Microlithiasis associated with acute pancreatitis (b) Post-cholecystectomy patients presenting with suspected biliary colic (after normal ultrasound and normal Liver Function Tests) 6) Pancreatic Tumours - Staging 7) Neuroendocrine Tumours - locating (including insulinomas and gastrinomas)				
200	Gastrostomy			General Surgical - Gastric
201	Percutaneous gastrostomy			General Surgical - Gastric
202	Upper gastrointestinal endoscopy with endoscopic ultrasound exam including oesophagus, and either the duodenum and/or jenjunum as appropriate		(I.P.), Diagnostic, Side Room	General Surgical - Gastric
203	Upper gastrointestinal endoscopy including oesophagus, stomach and either the duodenum and/or jenjunum as appropriate, with transendoscopic stent (includes pre-dilation) placement in patients with pancreatic cancer or recurrent gastric cancer			General Surgical - Gastric

Code	Description	Payment Rules	Payment Indicators	Speciality
204	Gastric antral vascular ectasia, endoscopic argon plasma photocoagulation of	Monitored Anaesthesia Benefit Only		General Surgical - Gastric
205	Gastrotomy/duodenotomy for haemorrhage			General Surgical - Gastric
206	Upper G.I. endoscopy with endoscopic mucosal resection	Please refer to note after code 192	See note on rule change	General Surgical - Gastric
215	Over sewing perforated peptic ulcer			General Surgical - Gastric
230	Rammstedt's operation			General Surgical - Gastric
235	Stomach transection			General Surgical - Gastric
241	Laparoscopic, surgical repair, epigastric/ventral hernia, (includes mesh insertion) initial or recurrent (I.P.)		I.P.	General Surgical - Hernia
243	Laparoscopic surgical repair, epigastric / ventral hernia (including mesh insertion when performed) initial or recurrent I.P.		I.P.	General Surgical - Hernia
244	Laparoscopic surgical repair, epigastric / ventral hernia (including mesh insertion when performed) incarcerated or strangulated I.P.		I.P.	General Surgical - Hernia
245	Epigastric/Ventral hernia, repair of (I.P.)		(I.P.)	General Surgical - Hernia
246	Exomphalos, minor			General Surgical - Hernia
247	Exomphalos, major			General Surgical - Hernia
248	Exomphalos, delayed			General Surgical - Hernia
249	Laparoscopic, surgical repair, epigastric/ventral hernia, (includes mesh insertion) incarcerated or strangulated (I.P.)		I.P.	General Surgical - Hernia
250	Femoral hernia, repair of, bilateral			General Surgical - Hernia
255	Femoral hernia, repair of, unilateral (I.P.)		(I.P.)	General Surgical - Hernia
270	Hiatus hernia, abdominal repair of			General Surgical - Hernia
271	Laparoscopic repair of hiatus hernia	See note below		General Surgical - Hernia
1. Referral following investigation and treatment by a Gastroenterologist registered with Aviva and who conforms to our definition of a consultant. 2. Failure of trial of adequate medical treatment - duration and type of treatment to be specified. 3. Previous gastroscopy with histological proof of oesophagitis. 4. 24 hour ambulatory pH study identifying a) a pH of less than 4 or greater than 5% of the day, and b) a de Meester score greater than 15. 5. Further evidence in support of surgery, where possible, from pressure studies would be desirable. The clinical indications described on the claim form will be monitored and may be reviewed from time to time as practice dictates.				
275	Hiatus hernia, transthoracic, repair of (I.P.)		(I.P.)	General Surgical - Hernia

Code	Description	Payment Rules	Payment Indicators	Speciality
276	Laparoscopic surgical repair of incisional hernia (includes mesh insertion) (initial or recurrent) (I.P.)		I.P.	General Surgical - Hernia
277	Laparoscopic surgical repair of incisional hernia (includes mesh insertion)); incarcerated or strangulated (I.P.)		I.P.	General Surgical - Hernia
278	Laparoscopic surgical repair of incisional hernia (includes mesh insertion, when performed)initial or recurrent I.P.		I.P.	General Surgical - Hernia
279	Laparoscopic surgical repair of incisional hernia (includes mesh insertion, when performed)incarcerated or strangulated I.P.		I.P.	General Surgical - Hernia
280	Incisional hernia, repair of (I.P.)		(I.P.)	General Surgical - Hernia
283	Inguinal hernia, neonate up to six weeks of age, laparoscopic repair of, unilateral (I.P.)		(I.P.)	General Surgical - Hernia
284	Inguinal hernia, laparoscopic repair of, bilateral (I.P.)		(I.P.)	General Surgical - Hernia
285	Inguinal hernia, repair of, bilateral (I.P.)		(I.P.)	General Surgical - Hernia
286	Inguinal hernia, neonate up to six weeks of age, laparoscopic repair of, bilateral (I.P.)		(I.P.)	General Surgical - Hernia
287	Inguinal hernia, laparoscopic repair of, unilateral (I.P.)	Max. 1 night Hospital Stay		General Surgical - Hernia
288	Strangulated inguinal hernia, laparoscopic repair of, unilateral (I.P.)		(I.P.)	General Surgical - Hernia
289	Repair of inguinal hernia, neonate up to six weeks of age, bilateral (I.P.)		(I.P.)	General Surgical - Hernia
290	Inguinal hernia, repair of, unilateral (I.P.)	Max. 1 night Hospital Stay		General Surgical - Hernia
291	Strangulated inguinal hernia, unilateral (I.P.)		(I.P.)	General Surgical - Hernia
292	Repair of inguinal hernia, neonate up to six weeks of age, unilateral (I.P.)		(I.P.)	General Surgical - Hernia
295	Patent urachus, closure and repair of abdominal muscles			General Surgical - Hernia
305	Recurrent hernia, repair of (I.P.)		(I.P.)	General Surgical - Hernia
310	Umbilical hernia, repair of (I.P.)	Max. 1 night Hospital Stay		General Surgical - Hernia
320	Congenital defects, correction of (including Meckel's diverticulum)			General Surgical - Jejunum & Ileum
331	Gastroschisis			General Surgical - Jejunum & Ileum
355	Ileostomy or laparoscopic loop illeostomy(I.P.)		(I.P.)	General Surgical - Jejunum & Ileum

Code	Description	Payment Rules	Payment Indicators	Speciality
356	Ileoscopy, through stoma, with or without biopsy		Diagnostic, Side Room, Monitored Anaesthesia Care	General Surgical - Jejunum & Ileum
360	Resection of small intestine; single resection and anastamosis			General Surgical - Jejunum & Ileum
361	Intestinal atresia, single/multiple			General Surgical - Jejunum & Ileum
362	Intestinal stricturalplasty (enterotomy & enterorrahaphy) with or without dilation, for intestinal obstruction			General Surgical - Jejunum & Ileum
363	Intestinal stricturalplasty (enterotomy & enterorrahaphy) with or without dilation, for intestinal obstruction, multiple, 3 or more			General Surgical - Jejunum & Ileum
364	Hydrostatic reduction of intussusception			General Surgical - Jejunum & Ileum
370	Jejunostomy			General Surgical - Jejunum & Ileum
384	Laparoscopic resection and anastamosis of jejunum or ileum			General Surgical - Jejunum & Ileum
385	Resection and anastomosis of jejunum or ileum			General Surgical - Jejunum & Ileum
386	Surgical reduction of intussusception including repair with or without appendicectomy			General Surgical - Jejunum & Ileum
389	Anal canal EUA (I.P.)		(I.P.) , Daycare	General Surgical - Jejunum & Ileum
390	Anal canal, plastic repair of (for incontinence)			General Surgical - Jejunum & Ileum
391	Laparoscopic, low anterior resection with coloanal anastamosis			General Surgical - Jejunum & Ileum
392	Laparoscopic, mid/high anterior resection with coloanal anastamosis			General Surgical - Jejunum & Ileum
395	Anal fissure, dilatation of anus (I.P.)		(I.P.) , Daycare	General Surgical - Large Intestine
396	Anoplasty for low anorectal anomaly			General Surgical - Large Intestine
397	Anorectal anomaly, (posterior sagittal anorectoplasty PSARP), for high/inter			General Surgical - Large Intestine
399	Monitored anaesthesia benefit for surgical procedures	Monitored Anaesthesia Care		Anaesthesia
400	Lateral internal sphincterotomy (I.P.)		(I.P.) , Daycare	General Surgical - Large Intestine
401	Botulinum toxin injection of anal sphincter under general anaesthetic		Daycare	General Surgical - Large Intestine

Code	Description	Payment Rules	Payment Indicators	Speciality
14405	Destruction of lesion(s) by any method, genital/anal warts (e.g. condyloma, papilloma, molluscum contagiosum, herpetic vesicle) where performed under General anaesthetisc in an Aviva approved hospital (I.P.)			General Surgical - Large Intestine
410	Anus, excision of epithelioma of, with colostomy		Daycare	General Surgical - Large Intestine
415	Anus, excision of epithelioma of, without colostomy		Daycare	General Surgical - Large Intestine
420	Caecostomy (I.P.)		(I.P.)	General Surgical - Large Intestine
425	Caecostomy or colostomy, closure of			General Surgical - Large Intestine
430	Colectomy, partial			General Surgical - Large Intestine
431	Laparoscopic colectomy, partial			General Surgical - Large Intestine
432	Laparoscopic colectomy, total			General Surgical - Large Intestine
433	Laparoscopic colectomy, total with ileal pouch reconstruction			General Surgical - Large Intestine
434	Laparoscopic surgical closure of enterostomy, large or small intestine, with resection and anastomosis			General Surgical - Large Intestine
435	Colectomy, total			General Surgical - Large Intestine
436	Total colectomy and ileal pouch construction with temporary ileostomy			General Surgical - Large Intestine
437	Closure of ileostomy			General Surgical - Large Intestine
438	Total colectomy for toxic megacolon			General Surgical - 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			General Surgical - Large Intestine
448	Double balloon enteroscopy (antegrade or retrograde) (see note below)	See note below	Day Care Diagnostic Service	General Surgery - Large Intestine

1). 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;
2). For initial diagnosis in persons with suspected Chrone'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; or
3). for treating members with gastrointestinal bleeding when the small intestine has been identified as the source of bleeding.

Code	Description	Payment Rules	Payment Indicators	Speciality
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			General Surgical - Large Intestine
450	Colonoscopy, one side	See note below	See note on rule change	General Surgical - Large Intestine
1. Benefit, in accordance with the Ground Rules, will be payable for an initial colonoscopic, proctoscopic or sigmoidoscopic examination. 2. 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: - Following removal of adenomas with dysplasia. - Multiple or large adenomas which could not be satisfactorily cleared in one endoscopy session. - Pre-operative assessment of chronic inflammatory bowel disease (IBD). - Relapse of IBD following change of therapy. - Post-colonic cancer surgery at 1, 3 and 5 years. - Cancer surveillance in chronic pan ulcerative colitis. - 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: (a) Colonic polyps (b) Colonic carcinoma (c) Inflammatory bowel disease (d) Blood stained mucus or stool coming from beyond the range of a left sided colon examination 3. Repeat full colonoscopy when there is unexplained deterioration in symptomatology not explained by left sided colonoscopy 4. Left colonoscopy to assess disease activity at the time of significant reduction or withdrawal of medication. 5. Left colonoscopy at the time of significant symptomatic relapse. 6. 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. 7. Evaluation of an abdominal mass 8. New clinical indications unrelated to the original indications for endoscopy, themselves an identified indication for endoscopy, will not be excluded by a prior endoscopy. 9. When a barium enema is carried out following a colonoscopy, the benefit for a one side colonoscopy, proctoscopy or sigmoidoscopy only is payable. 10. Clinical indications for which we pay for surveillance colonoscopy: A. Individuals who have two first degree relatives diagnosed with colorectal cancer. B. Individuals with a family history of polyposis coli. C. Individuals with a family history of hereditary non-polyposis coli. D. 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 (A) to (D) we will pay an initial colonoscopy and, if normal, repeats at 5 yearly intervals.				
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)	Side room only, Service	see note on rule change	General Surgical - Large Intestine
455	Colonoscopy, both sides	Please refer to note under code 450	see note on rule change	General Surgical - Large Intestine
456	Colonoscopy plus polypectomy	Please refer to note under code 450	see note on rule change	General Surgical - Large Intestine
457	Colonoscopy plus polypectomy, full colon	Please refer to note under code 450	see note on rule change	General Surgical - Large Intestine
458	Left colonoscopy and laser photocoagulation of rectum		Side Room, Monitored Anaesthesia Care	General Surgical - Large Intestine
459	Colonoscopy, full colon and laser photocoagulation of rectum		Daycare, Monitored Anaesthesia Care	General Surgical - Large Intestine
460	Colostomy (I.P.)		(I.P.)	General Surgical - Large Intestine
461	Reduction of prolapsed colostomy stoma			General Surgical - Large Intestine
465	Resection of bowel and colostomy or anastomosis for diverticulitis			General Surgical - Large Intestine

Code	Description	Payment Rules	Payment Indicators	Speciality
466	Endoscopic transanal resection of large (>2cm) villous adenomas/ malignant tumours of rectum (ETART), using resectoscope			General Surgical - Large Intestine
467	Colonoscopy with transendoscopic stent placement (includes pre dilation)			General Surgical - Large Intestine
468	Excision of rectal tumour, transanal approach			General Surgical - Large Intestine
470	Faecal fistula, closure or resection			General Surgical - Large Intestine
485	Anal fistulotomy	Max. 1 night Hospital Stay	I.P	General Surgical - Large Intestine
486	Fistula-in-ano, excision with endo-anal flap and advancement (I.P.)		(I.P.)	General Surgical - Large Intestine
487	Fistula-in-ano, insertion/change of seton (I.P.)		(I.P.) , Daycare	General Surgical - Large Intestine
488	Ani-rectal manometry		Diagnostic, Side Room	General Surgical - Large Intestine
490	Haemorrhoidectomy (external) (I.P.)		(I.P.) , Daycare	General Surgical - Large Intestine
495	Haemorrhoidectomy, external, multiple (I.P.)		(I.P.) , Daycare	General Surgical - Large Intestine
500	Haemorrhoidectomy (internal) includes exploration of anal canal (I.P.)		(I.P.)	General Surgical - Large Intestine
501	Haemorrhoidopexy (e.g. for prolapsing internal haemorrhoids) by stapling (eg Stapled Haemorrhoidectomy)	Max. 1 night Hospital Stay		General Surgical - Large Intestine
506	Haemorrhoids, injection and/or banding (I.P.)		(I.P.) , Side Room	General Surgical - Large Intestine
513	Meconium ileus, open reduction with or without stoma			General Surgical - Large Intestine
514	Meconium ileus reduction			General Surgical - Large Intestine
515	Imperforate anus, simple incision			General Surgical - Large Intestine
516	Necrotising enterocolitis, percutaneous drainage			General Surgical - Large Intestine
517	Necrotising enterocolitis, laparotomy resection/stoma			General Surgical - Large Intestine
518	Panproctocolectomy			General Surgical - Large Intestine
520	Imperforate anus, with colostomy or pull through operation			General Surgical - Large Intestine

Code	Description	Payment Rules	Payment Indicators	Speciality
530	Proctoscopy or sigmoidoscopy (I.P.)	Please refer to note under code 450	See note on rule change	General Surgical - Large Intestine
535	Proctoscopy or sigmoidoscopy, with biopsy	Please refer to note under code 450	Diagnostic, Side Room, Monitored Anaesthesia Care	General Surgical - Large Intestine
536	Diagnostic flexible sigmoidoscopy and biopsies	Please refer to note under code 450	See note on rule change	General Surgical - Large Intestine
540	Proctoscopy or sigmoidoscopy with biopsy of muscle coats of bowel, for megacolon		See note on rule change	General Surgical - Large Intestine
545	Prolapse of rectum, abdominal approach involving laparotomy, colostomy or intestinal anastomosis including laparoscopic approach			General Surgical - Large Intestine
549	Delorme procedure			General Surgical - Large Intestine
550	Prolapse of rectum, perineal repair (I.P.)		(I.P.)	General Surgical - Large Intestine
555	Closure of rectovesical fistula, with or without colostomy (I.P.)		(I.P.)	General Surgical - Large Intestine
556	Balloon dilation of the rectum		Daycare	General Surgical - Large Intestine
560	Rectal or sigmoid polypi (removal by diathermy etc.)		Daycare	General Surgical - Large Intestine
565	Rectum, excision of (all forms including perineoabdominal, perineal anterior resection and laparoscopic approach)			General Surgical - Large Intestine
570	Rectum, partial excision of			General Surgical - Large Intestine
574	Presacral teratoma, excision of			General Surgical - Large Intestine
576	Revision/refashioning of ileostomy and duodenostomy, complicated reconstruction in-depth (I.P.)		(I.P.)	General Surgical - Large Intestine
577	Low anterior resection with coloanal anastomosis for cancer			General Surgical - Large Intestine
578	Soave procedure			General Surgical - Large Intestine
579	Internal sphincter myomectomy in children with Hirschsprung disease			General Surgical - Large Intestine
581	Sigmoidoscopy including dilatation of intestinal strictures		Daycare	General Surgical - Large Intestine
582	Proctectomy for recurrent rectal cancer in a radiated and previously operated pelvis			General Surgical - Large Intestine

Code	Description	Payment Rules	Payment Indicators	Speciality
585	Stricture of rectum (dilation of) (I.P.)		(I.P.) , Daycare	General Surgical - Large Intestine
590	Volvulus (stomach, small bowel or colon, including resection and anastomosis)			General Surgical - Large Intestine
591	Correction of malrotation by lysis of duodenal bands and/or resection of midgut volvulus (e.g. Ladd procedure)			General Surgical - Large Intestine
595	Hepatotomy for drainage of abscess or cyst, one or two stages			General Surgical - Liver
600	Biopsy of liver (by laparotomy) (I.P.)		(I.P.) , Diagnostic	General Surgical - Liver
601	Transjugular liver biopsy		Diagnostic	General Surgical - Liver
605	Biopsy of liver (needle)		Diagnostic	General Surgical - Liver
608	Management of liver haemorrhage; simple suture of liver wound or injury			General Surgical - Liver
611	Major liver resection			General Surgical - Liver
612	Portoenterostomy (e.g. Kasai procedure)			General Surgical - Gall Bladder & Bile Ducts
616	Wedge resection of liver			General Surgical - Liver
617	Intrahepatic cholangioenteric anastomosis			General Surgical - Liver
618	Resection of hilar bile duct tumour			General Surgical - Liver
619	Management of liver haemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver			General Surgical - Liver
622	Insertion of hepatic artery catheter and reservoir pump			General Surgical - Liver
625	Liver, left lateral lobectomy			General Surgical - Liver
626	Intra-operative radiofrequency ablation of liver metastases			General Surgical - Liver
630	Excision of hydatid cyst			General Surgical - Liver
645	Epididymectomy, unilateral (I.P.)		(I.P.)	Urology Procedures
655	Hydrocelectomy, bilateral (I.P.)		(I.P.)	Urology Procedures
660	Hydrocelectomy, unilateral (I.P.)	Max. 1 night Hospital Stay	I.P.	Urology Procedures
664	Meatoplasty (I.P.)		(I.P.) , Daycare	Urology Procedures
665	Meatotomy (I.P.)		(I.P.) , Daycare	Urology Procedures
666	Urethroplasty for penile or bulbar urethral stricture			Urology Procedures
667	Acute repair of rupture of membranous urethra			Urology Procedures
668	Urethroplasty for repair of prostatic or membranous urethral stricture, complete procedure			Urology Procedures
669	Orchidectomy, radical, for cancer,inguinal approach			Urology Procedures

Code	Description	Payment Rules	Payment Indicators	Speciality
670	Orchidectomy, bilateral (I.P.)		(I.P.)	Urology Procedures
671	Subcutaneous testosterone implantation for hypogonadotrophic hypogonadism		Side Room	Urology Procedures
672	Drainage of intra-scrotal abscess (I.P.)		(I.P.)	Urology Procedures
673	Orchidectomy, radical, for cancer,inguinal approach including artificial prosthesis			Urology Procedures
674	Orchidectomy, radical, for cancer,with abdominal exploration			Urology Procedures
675	Orchidectomy, unilateral (I.P.)		(I.P.)	Urology Procedures
676	Removal of implantated inflatable urethral/bladder neck sphincter, including pump, resevoir and cuff (AUS)			Urology Procedures
677	Hypospadias, MAGPI procedure		Daycare	Urology Procedures
679	Orchidectomy, radical, for cancer, with abdominal exploration including artificial prosthesis			Urology Procedures
681	Injection of corpora cavernosa with pharmacologic agent(s) (e.g. papaverine, phentolamine)		Side Room	Urology Procedures
683	Circumcision		Daycare	Urology Procedures
684	Circumcision for BXO (Balantis Xerotica Obllterans). Full Histology report must accompany claim		I.P.	Urology Procedures
685	Penis, amputation of, partial			Urology Procedures
687	Penis, amputation of, total			Urology Procedures
688	Biopsy of penis (I.P.)		(I.P.) , Diagnostic, Daycare	Urology Procedures
692	Excision of penile plaque with or without graft			Urology Procedures
693	Nesbit procedure (plastic operation on penis to correct angulation)			Urology Procedures
694	Removal of penile prosthesis			Urology Procedures
695	Prepuce, dorsal incision of		Daycare	Urology Procedures
696	Release of priapism (needle drainage)			Urology Procedures
697	Excision of epididymal cyst(s), unilateral (I.P.)		(I.P.) , Daycare	Urology Procedures
698	Excision of epididymal cyst(s), bilateral (I.P.)		(I.P.) , Daycare	Urology Procedures
699	Epididymectomy, bilateral (I.P.)		(I.P.)	Urology Procedures
700	Transurethral prostatectomy			Urology Procedures
701	Radical retropubic nerve sparing prostatectomy (includes bilateral pelvic lymph adenectomy with bladder neck reconstruction and anastomosis to the urethra)			Urology Procedures

Code	Description	Payment Rules	Payment Indicators	Speciality
703	Insertion of an endo urethral stent for urethral stricture		Daycare	Urology Procedures
704	Epididymovasostomy, bilateral			Urology Procedures
707	Laser (Green Light) vaporisation of prostate including control of post operative bleeding, complete (vasectomy meatotomy, cystorethroscopy, urethral calibration and/or dilation, internal uretherotomy and transurethral resection of prostate are included if performed	Max. 1 night Hospital Stay		Urology Procedures
708	Open prostatectomy			Urology Procedures
709	Laparoscopic surgical prostatectomy, retropubic radical, including nerve sparing (includes robotic assisted prostatectomy with the De Vinci Prostatectomy Radical system)			Urology Procedures
713	Biopsy of prostate (perineal or transrectal) includes ultrasound guidance (I.P.)		(I.P.) , Diagnostic, Side Room	Urology Procedures
714	Laparoscopy, orchidopexy for intra-abdominal testis (includes impalapable High Jones procedure)		Daycare	Urology Procedures
715	Orchidopexy, inguinal approach with or without hernia repair, unilateral (I.P.)		(I.P.) , Daycare	Urology Procedures
716	Laser enucleation of the prostate with morcellation including control of postoperative bleeding, complete (vasectomy meatotomy, cystorethroscopy, urethral calibration and/or dilation, internal uretherotomy and transurethral resection of prostate are included if performed)	Max. 1 night Hospital Stay		Urology Procedures
717	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including image guidance under general anaesthetic (see note below)	Conditions of payment for code 717 are as follows: 1) At least three previous negative extended prostate biopsies 2) Histologic evidence of atypia on prior prostate biopsy 3) Histologic findings of high-grade prostatic intraepithelial neoplasia (PIN) on prior biopsy	Day Care	Urology Procedures - Prostate
720	Orchidopexy, inguinal approach with or without hernia repair, bilateral (I.P.)		(I.P.) , Daycare	Urology Procedures
735	Orchidopexy, unilateral for torsion and exploration of opposite side			Urology Procedures
736	Orchidopexy, abdominal approach for intra-abdominal testis (e.g. Fowler - Stephens)		Daycare	Urology Procedures
740	Testicular biopsy (needle) (I.P.)		(I.P.) , Diagnostic, Daycare	Urology Procedures
741	Testicular Biopsy (open surgical) (I.P.)		(I.P.) , Diagnostic, Daycare	Urology Procedures
742	Testicular prosthesis, insertion/ replacement/removal of, unilateral			Urology Procedures

Code	Description	Payment Rules	Payment Indicators	Speciality
743	Testicular prosthesis, insertion/ replacement/removal of, bilateral			Urology Procedures
755	Varicocelectomy		Daycare	Urology Procedures
771	ERCP sphincterotomy and extraction of stones			General Surgical - Pancreas
772	ERCP sphincterotomy and insertion of endoprosthesis			General Surgical - Pancreas
773	Biopsy of pancreas, percutaneous needle, includes radiological or ultrasound guidance			General Surgical - Pancreas
774	ERCP (endoscopic retrograde cholangiogram of pancreas)		Diagnostic	General Surgical - Pancreas
775	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple - type procedure); with pancreatojejunostomy			General Surgical - Pancreas
776	Pancreatic biopsy		Diagnostic	General Surgical - Pancreas
778	Pancreaticojejunostomy			General Surgical - Pancreas
779	ERCP ampullectomy with insertion of endoprosthesis			General Surgical - Pancreas
780	Distal pancreatectomy including splenectomy			General Surgical - Pancreas
781	Endoscopic cannulation of papilla with direct visualisation (spy glass probe) of common bile duct(s) and/or pancreatic ducts (benefit shown is payable in full with the code for main procedure, 771,772,774,779 or 782)		Diagnostic Service	General Surgical Operations- Pancreas
782	ERCP with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method			General Surgical Operations- Pancreas
785	Total pancreatectomy, distal, with gastrectomy, splenectomy, duodenectomy, cholecystectomy and resection of distal bile duct			General Surgical - Pancreas
786	Simultaneous pancreas/kidney transplant			General Surgical - Pancreas
790	Open surgical drainage of pancreatic abscess or pseudocyst			General Surgical - Pancreas
795	Pancreatotomy for drainage of pancreatitis, abscess or cyst with exploration of biliary and pancreatic duct			General Surgical - Pancreas
800	Splenectomy (I.P.)		(I.P.)	General Surgical - Spleen
806	Transcatheter ablation of function of spleen			General Surgical - Spleen
807	Aspiration of splenic cysts			General Surgical - Spleen

Code	Description	Payment Rules	Payment Indicators	Speciality
820	Arteriovenous anastomosis in arm			Urology Procedures
821	Gortex graft placement for AV access for dialysis			General Surgical - Dialysis
822	Creation of permanent shunt involving dissection of vessel/ tunnelling, insertion of shunt, suturing to vein or artery for access for haemodialysis			General Surgical - Dialysis
823	Home based haemodialysis, self dialysis training (max. 18 sessions)	Max. 18 Sessions		General Surgical - Dialysis
824	Haemodialysis, chronic, in the patient's home or at a hospital out patient department, after completion of training sessions, monthly benefit	Minimum of 3 dialysis sessions per week inclusive of all Consultant care. Monthly Benefit		General Surgical - Dialysis
825	Evaluation of a new patient requiring haemodialysis during a hospital admission including the insertion of vascath or similar, and the initial dialysis session	Paid once only for 1st session. For subsequent sessions use code 826		General Surgical - Dialysis
826	Haemodialysis procedure			General Surgical - Dialysis
828	Haemodialysis occurring during the course of another disease that necessitates in-patient hospital treatment			General Surgical - Dialysis
830	Evaluation of a new patient requiring peritoneal dialysis during a hospital admission including the insertion of an intraperitoneal cannula or catheter for drainage or dialysis, temporary, and the initial dialysis session	Paid once only for 1st session. For subsequent sessions use code 831		General Surgical - Dialysis
831	Peritoneal dialysis procedure after the establishment of permanent intraperitoneal cannula			General Surgical - Dialysis
833	Peritoneal dialysis/chronic in the patients home or at a hospital out-patient department after completion of training sessions, monthly benefit	Minimum of 3 dialysis sessions per week inclusive of all Consultant care. Monthly Benefit		General Surgical - Dialysis
834	Insertion of intraperitoneal cannula or catheter for drainage or dialysis, permanent	Refer to procedure 838 for the removal of permanent intraperitoneal canular catheter for drainage for dialysis (not for the removal of Hickman, Broviac, Vasath, or similar)		General Surgical - Dialysis
836	Bladder, instillation of anticarcinogenic agent (BCG or Mitomycin C)		Side Room	Urology Procedures
837	Continuous veno venous haemofiltration dialysis (CVVHD), per day			General Surgical - Dialysis
838	Removal of Tenchkoff catheter (not for the removal of Hickman, Broviac, Vascath or similar)	Refer to procedure 838 for the removal of permanent intraperitoneal canular catheter for drainage for dialysis (not for the removal of Hickman, Broviac, Vasath, or similar)		Urology Procedures
839	Bladder, DMSO instillation for interstitial cystitis		Side Room	Urology Procedures

Code	Description	Payment Rules	Payment Indicators	Speciality
841	Removal of permanent shunt inserted into vein or artery for access for haemodialysis (not for the removal of Hickman, Broviac, Vascath or similar)		Daycare	General Surgical - Dialysis
842	Insertion of intraperitoneal cannula or catheter for drainage or dialysis, temporary			General Surgical - Dialysis
843	Bladder, instillation of anticarcinogenic agent (bcg medac)		Side Room	Urology Procedures
844	Trials of micturition for urinary retention post-surgery.	Management of patient to include intravenous infusion of antibiotic, bladder instillation, removal of catheter and re-catheterisation of failure to void.	Day Care, Independent Procedure	Urology Procedures
846	Botulinium toxin injection to bladder wall only for idiopathic detrusor over activity in women who have not responded to conservative treatments (I.P.) (maximum of one injection payable per 12 month period since the last injection)		Day Care Service I.P.	Urology Procedures - Bladder
850	Bladder neck, transurethral resection of			Urology Procedures
855	Primary transurethral resection of bladder tumour(s), one or more (for diathermy of, use 885)			Urology Procedures
865	Cystectomy, partial			Urology Procedures
875	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis			Urology Procedures
877	Cystectomy, complete, with continent diversion, any technique, using any segment of small and/or large bowel to construct neobladder			Urology Procedures
878	Appendico-vesicostomy (Mitrofanoff procedure)			Urology Procedures
879	Cutaneous vesicostomy (I.P.)		(I.P.)	Urology Procedures
881	Cystoscopy with removal of JJ stent		Daycare	Urology Procedures
883	Cystoscopy with or without over distension with or without biopsy, with prostatic biopsy (I.P.)		(I.P.) , Diagnostic, Daycare	Urology Procedures
884	Cystoscopy with or without over distension, with or without biopsy (I.P.)		(I.P.) , Diagnostic, Daycare	Urology Procedures
885	Cystoscopy with diathermy to bladder tumour(s) (I.P.)		(I.P.) , Daycare	Urology Procedures
887	Cystoscopy with insertion of JJ stent			Urology Procedures
888	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds			Urology Procedures
889	Cystoureteroscopy with resection or fulguration of ectopic ureterocele(s) unilateral or bilateral in paediatric cases			Urology Procedures

Code	Description	Payment Rules	Payment Indicators	Speciality
890	Cystoscopy with ureteric catheterisation (I.P.)		(I.P.) , Diagnostic, Daycare	Urology Procedures
891	Cystoureteroscopy with ureteroscopy; with treatment of intra-renal stricture (e.g., balloon dilation, laser, electrocautery and incision)			Urology Procedures
895	Cystoscopy with ureteroscopy and removal of ureteric calculus (I.P.)		(I.P.)	Urology Procedures
896	Change of cystostomy tube (I.P.)		(I.P.) , Side Room	Urology Procedures
897	Cystolithotomy			Urology Procedures
898	Percutaneous suprapubic cystostomy (I.P.)	For procedure code 898 where monitored anaesthesia is required, claims must be supported by a medical report from the consultant anaesthetist outlining the necessity for monitored anaesthesia. See anaesthesia ground rule no.3 for monitored anaesthesia care.		Urology Procedures
899	Substitution cystoplasty			Urology Procedures
901	Closure of ruptured bladder (intraperitoneal)			Urology Procedures
906	Augmentation cystoplasty			Urology Procedures
907	Bladder neck, transurethral incision of			Urology Procedures
908	Excision of ureterocele in children including reconstruction and repair of sphincters including reimplantation of ureters			Urology Procedures
910	Excision of bladder diverticulum			Urology Procedures
914	Radical laparoscopic nephrectomy living donor			Urology Procedures
915	Embolisation of haemangioma of kidney			Urology Procedures
916	Laparoscopy, partial nephrectomy			Urology Procedures
917	Laparoscopy, radical nephrectomy			Urology Procedures
918	Laparoscopy , surgical, nephrectomy, with total uretherotomy			Urology Procedures
919	Laparoscopy, surgical, nephrectomy, including partial uretherotomy			Urology Procedures
920	Nephrectomy, partial			Urology Procedures
921	Radical nephrectomy (includes adrenalectomy and para-aortic lymph nodes)			Urology Procedures
922	Radical nephrectomy including caval extension above and/or below liver			Urology Procedures

Code	Description	Payment Rules	Payment Indicators	Speciality
923	Kidney transplant			Urology Procedures
924	Litholapaxy			Urology Procedures
925	Simple nephrectomy			Urology Procedures
930	Nephrolithotomy			Urology Procedures
931	Percutaneous nephrolithotomy			Urology Procedures
933	Percutaneous nephrolithotomy stag-horn calculus			Urology Procedures
934	Percutaneous nephrostomy with or without antegrade pyelogram or stent placement			Urology Procedures
936	Percutaneous tract formation for renal stone removal by another consultant (I.P.)		(I.P.)	Urology Procedures
937	Living donor nephrectomy			Urology Procedures
938	Nephrectomy with total ureterectomy and bladder cuff, through same incision			Urology Procedures
939	Nephrectomy with total ureterectomy and bladder cuff, through separate incisions			Urology Procedures
940	Pyelolithotomy			Urology Procedures
941	Percutaneous nephrolithotomy, pelvic or calyceal involving contact lithotripsy			Urology Procedures
945	Pyeloplasty			Urology Procedures
946	Pyeloplasty, complicated (congenital kidney abnormality secondary pyeloplasty, solitary kidney, calycoplasty) neonate up to one year of age			Urology Procedures
947	Radical nephrectomy in children (e.g. Wilms tumour) with contralateral exploration			Urology Procedures
948	Laparoscopy, surgical; pyeloplasty			Urology Procedures
955	Renal biopsy (needle)		Diagnostic	Urology Procedures
956	Renal cyst puncture and aspiration			Urology Procedures
960	Open suprapubic cystostomy (I.P.)		(I.P.)	Urology Procedures
973	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	Max. 1 night Hospital Stay	Diagnostic	Urology Procedures
974	Cystourethroscopy, with uretheroscopy and/or pyeloscopy; with resection of urethral or renal pelvic tumour			Urology Procedures
975	Open Ureterolithotomy			Urology Procedures
981	Ureterolysis, unilateral			Urology Procedures
982	Ureterolysis, bilateral			Urology Procedures
983	Ureteric reimplantation, unilateral for reflux, stricture or fistula (I.P.)		(I.P.)	Urology Procedures

Code	Description	Payment Rules	Payment Indicators	Speciality
984	STING procedure (initial)		Daycare	Urology Procedures
986	Ureteric reimplantation, bilateral for reflux, stricture or fistula (I.P.)		(I.P.)	Urology Procedures
987	STING procedure (repeat)		Daycare	Urology Procedures
989	Sling operation for the correction of male incontinence, with synthetic implant (I.P.) (see Note)	Condition of payment for code 989 and 998 is as follows: Benefit will be payable for patients who are six months post prostatectomy, who have had no improvement in the severity of urinary incontinence despite trials of behavioural and pharmacological therapies. One night only	I.P.	Urology Procedures - Ureter
992	Pubovaginal sling urethropexy			Urology Procedures
993	Vesico colic fistula, excision of, and sigmoid colectomy.	For cystocele, see procedure code 2415 gynaecological operations section. For urethropexy for stress incontinence refer to procedure code 245 gynaecological operations section.		Urology Procedures
994	Pubovaginal sling with cystocele repair or rectocele repair			Urology Procedures
995	Ureterostomy, unilateral			Urology Procedures
996	Ureteric substitution (with bowel segment)			Urology Procedures
997	Pubovaginal sling including cystocele and rectocele repair			Urology Procedures
998	Sling operation for the correction of male incontinence (e.g. Fascia or synthetic)(I.P.)	Max. 1 night Hospital Stay. 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	I.P.	Urology Procedures
1000	Ureterostomy, bilateral			Urology Procedures
1015	Urethral dilatation (I.P.)		(I.P.) , Side Room	Urology Procedures
1029	Complex uroflowmetry (using calibrated electronic equipment); for initial evaluation of bladder outlet obstruction and uncomplicated urge incontinence with or without ultrasound, with post void residual ultrasound screening in an Aviva approved hospital Urodynamic laboratory		Side Room	Urology Procedures
1030	Optical uretherotomy (I.P.)		(I.P.)	Urology Procedures

Code	Description	Payment Rules	Payment Indicators	Speciality
1031	Complex cystometrogram using calibrated electronic equipment and urethral pressure profile studies (minimum of 2 fills), with measurement of post-voiding residual urine by ultrasound in an Aviva approved hospital Urodynamic laboratory		Side Room	Urology Procedures
1032	Implantation of inflatable urethral/bladder neck sphincter, including pump, reservoir and cuff (AUS)			Urology Procedures
1033	Whittaker test for evaluation of upper urinary tract obstruction		Diagnostic	Urology Procedures
1041	Carotid body tumour greater than 4 cms			General Surgical - Head & Neck - Arteries
1042	Carotid body tumour less than 4 cms			General Surgical - Head & Neck - Arteries
1046	Excision of lesion of mucosa and submucosa, vestibule of mouth, with simple repair (I.P.)	Vestibule is the part of the oral cavity outside the dentoalveolar structure; it includes the mucosal and submucosal tissues of lips and cheeks	I.P. , Side Room	General Surgical - Head & Neck - Mouth/Cheek
1047	Excision of lesion of mucosa and submucosa, vestibule of mouth, complex, with or without excision of underlying muscle (I.P.)	Vestibule is the part of the oral cavity outside the dentoalveolar structure; it includes the mucosal and submucosal tissues of lips and cheeks	I.P , Daycare	General Surgical - Head & Neck - Mouth/Cheek
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.)	Vestibule is the part of the oral cavity outside the dentoalveolar structure; it includes the mucosal and submucosal tissues of lips and cheeks	I.P.	General Surgical - Head & Neck - Mouth/Cheek
1055	Cyst or benign tumour on lip, excision of (I.P.)		(I.P.) , Side Room, Service	General Surgical - Head & Neck - Lips
1058	Epithelioma of lip, lip shave		Side Room	General Surgical - Head & Neck - Lips
1059	Epithelioma of lip, wedge excision		Daycare	General Surgical - Head & Neck - Lips
1065	Branchial cyst, pouch or fistula, excision of			General Surgical - Head & Neck - Neck
1075	Cysts or tuberculosis glands of neck (deep to deep fascia) excision of		Daycare	General Surgical - Head & Neck - Neck
1080	Selective neck dissection			General Surgical - Head & Neck - Neck
1082	Radical neck dissection			General Surgical - Head & Neck - Neck
1085	Thyroglossal cyst or fistula, excision of			General Surgical - Head & Neck - Neck
1090	Torticollis, partial excision, open correction of			General Surgical - Head & Neck - Neck

Code	Description	Payment Rules	Payment Indicators	Speciality
1095	Tuberculous caseous glands or sinuses, curettage of			General Surgical - Head & Neck - Neck
1096	Oesophageal anastomosis, (repair and short circuit)			General Surgical - Head & Neck - Oesophagus
1097	Partial Oesophagectomy			General Surgical - Head & Neck - Oesophagus
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)			General Surgical - Head & Neck - Oesophagus
1100	Laceration of palate, repair of			General Surgical - Head & Neck - Palate
1104	Biopsy lesion of palate (minimum 2 cm)		Side Room	General Surgical - Head & Neck - Palate
1105	Radical operation for malignant growth of palate			General Surgical - Head & Neck - Palate
1106	Partial maxillectomy including plastic reconstruction			General Surgical - Head & Neck - Maxilla
1107	Total maxillectomy including plastic reconstruction			General Surgical - Head & Neck - Maxilla
1108	Fabrication and provision of surgical maxillary obturator	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1109	Fabrication and provision of interim obturator (unilateral or partial maxillectomy)	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1110	Parathyroid adenoma, excision of			General Surgical - Parathyroid Glands
1111	Transcatheter ablation of function of parathyroid glands			General Surgical - Parathyroid Glands

Code	Description	Payment Rules	Payment Indicators	Speciality
1112	Parathyroid hyperplasia, excision of (4 glands, frozen section)			General Surgical - Parathyroid Glands
1113	Total parathyroidectomy with auto transplant or mediastinal exploration/intra-thoracic			General Surgical - Parathyroid Glands
1114	Parathyroid re-exploration			General Surgical - Parathyroid Glands
1115	Abscess of salivary gland, incision and drainage			General Surgical - Salivary Glands
1116	Fabrication and provision of interim obturator (bilateral or total maxillectomy)	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1117	Fabrication and provision of definitive obturator (unilateral or partial maxillectomy)	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1118	Fabrication and provision of definitive obturator (bilateral or total maxillectomy)	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1119	Fabrication of mandibular resection denture	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				

Code	Description	Payment Rules	Payment Indicators	Speciality
1120	Fistula of salivary duct, repair of			General Surgical - Salivary Glands
1121	Prosthetic surgical graft locator, one arch	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1122	Prosthetic surgical graft locator, both arches	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1123	Palatal drop prosthesis	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1124	Cranial implant	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1125	Parotid or submandibular duct, dilatation of			General Surgical - Salivary Glands
1126	Submandibular duct, relocation			General Surgical - Salivary Glands

Code	Description	Payment Rules	Payment Indicators	Speciality
1127	Complete nasal prosthesis (more than half)	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1128	Auricular prosthesis	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1129	Partial nasal prosthesis (less than half)	See note below		General Surgical - Head & Neck - Maxillofacial Prosthesesis
Note 1: The specialist performing maxillofacial prosthesis codes 1108, 1109,1116,1117,1118,1119,1121,1122,1123,1124,1127,1129,1128 must be approved by Aviva for performing these procedures before benefit can be approved. Full details of the training programme completed in maxillofacial prosthesis and the postgraduate training programme carried out must be forwarded to Aviva so that we can assess eligibility. Benefit in respect of obturator prosthesis excludes those prosthetic procedures carried out in general dental practice and refer specifically to the need for obduration following surgery from the malignant lesions or extensive loss of jaw and dental tissue consequent to trauma. The benefit for maxillofacial prosthesis is all inclusive for intra-operative and post-operative impressions, mould-making and design fabrication and fitting of the prosthesis including fitting all necessary anatomical retentive devices. Note 2: Composite fee will apply; - when two are made reduced by EUR161.93, when three are made reduce by EUR332.89				
1133	Excision of parotid tumour or parotid gland, lateral lobe, (superficial parotidectomy) with dissection and preservation of facial nerve			General Surgical - Salivary Glands
1134	Excision of parotid tumour or parotid gland, total, en bloc removal with sacrifice of facial nerve			General Surgical - Salivary Glands
1135	Excision of parotid tumour or parotid gland, total with dissection and preservation of facial nerve			General Surgical - Salivary Glands
1136	Excision of parotid tumour or parotid gland, lateral lobe, without nerve dissection			General Surgical - Salivary Glands
1140	Salivary calculus, removal of		Daycare	General Surgical - Salivary Glands
1141	Sialendoscopy with sialolithiasis, any method; complicated intraoral (I.P.)		I.P.	General Surgical- Salivary Glands
1150	Submandibular salivary gland, excision of			General Surgical - Salivary Glands

Code	Description	Payment Rules	Payment Indicators	Speciality
1151	Excision of sublingual gland			General Surgical - Salivary Glands
1152	Thyroid cyst(s) aspiration/fine needle biopsy (I.P.)		(I.P.) , Side Room	General Surgical - Thyroid Gland
1154	Excision of thyroid cyst			General Surgical - Thyroid Gland
1155	Total/revision thyroidectomy			General Surgical - Thyroid Gland
1156	Percutaneous core needle biopsy of thyroid gland (I.P.)	For fine needle biopsy use procedure code 1152		General Surgical - Thyroid Gland
1157	Partial/subtotal thyroidectomy			General Surgical - Thyroid Gland
1158	Radiopharmaceutical therapy ; initial consultation and planning on an outpatient basis followed by radiopharmacutical therapy (I-131) hyperthroidism on a subsequent day		Side Room	Radiotherapy
1159	Radiopharmaceutical Therapy; initial consultation and planning on an outpatient basis followed by a radiopharmacutical (I-131) ablation of gland for thyroid carncinoma on a subsequent day			Radiotherapy
1165	Excision of epithelioma of tongue with radical operation on glands			General Surgical - Tongue
1170	Frenectomy (tongue tie)		Daycare	General Surgical - Tongue
1174	Glossectomy; less than one-half tongue			General Surgical - Tongue
1175	Hemiglossectomy			General Surgical - Tongue
1176	Total glossectomy			General Surgical - Tongue
1180	Growths of tongue, diathermy to		Side Room	General Surgical - Tongue
1185	Excision biopsy, oral cavity (I.P.)		(I.P.) , Side Room	General Surgical - Tongue
1186	Resection of tonsil, tongue base, palate, mandible and radical neck dissection			General Surgical - Tongue
1190	Abscess, incision and drainage of		Side Room, Service	General Surgical - Breast
1191	Breast cyst(s) aspiration/fine needle biopsy (diagnostic or therapeutic) (I.P.)		(I.P.) , Side Room, Service, Private Rooms	General Surgical - Breast
1195	Percutaneous core needle biopsy of breast with or without ultrasound guidance (I.P.)	For fine needle biopsy use procedure code 1191		General Surgical - Breast

Code	Description	Payment Rules	Payment Indicators	Speciality
1198	Re-excision of margins arising from pervious breast surgery (I.P.)		(I.P.) , Daycare	General Surgical - Breast
1199	Placement of radiotherapy after loading catheter(s) into the breast for interstitial radioelement (brachytherapy) application at the same time or subsequent to breast surgery, includes imaging guidance.	50% benefit applies if carried out at the same session as breast surgery		Radiotherapy
1200	Cysts or tumours, excision of, or lumpectomy, segmental resection, quadrant mastectomy or partial mastectomy		Daycare	General Surgical - Breast
1201	Excision of breast lesions identified by preoperative placement of radiological markers. Procedure includes specimen mammography, extension of margins and placement of orientation markers for later radiotherapy (hospital benefits apply for a maximum stay of one night only) (only claimable when all elements of the description have been carried out (I.P.)		(I.P.)	General Surgical - Breast
1202	Excision of breast lesions identified by preoperative placement of radiological markers. Procedure includes specimen mammography, extension of margins and placement of orientation markers for later radiotherapy with removal of sentinel nodes (hospital benefits apply for a maximum stay of one night only) (only claimable when all elements of the description have been carried out (I.P.)		(I.P.)	General Surgical - Breast
1203	Excision of breast lesions identified by preoperative placement of radiological markers. Procedure includes specimen mammography, extension of margins and placement of orientation markers for later radiotherapy with axillary clearance (only claimable when all elements of description have been carried out)			General Surgical - Breast
1204	Mastectomy, simple, complete with removal of sentinel node(s)		(I.P.)	General Surgical - Breast
1205	Duct papilloma, excision of		Daycare	General Surgical - 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			General Surgical - Breast
1207	Skin sparing mastectomy with free skin and/or muscle flap with microvascular anastomosis (IP)		(I.P.)	General Surgical - Breast
1208	Open periprosthetic capsulotomy breast			General Surgical - Breast
1209	Periprosthetic capsulotomy breast			General Surgical - Breast
1210	Gynaecomastia (excision for), unilateral. **Pre-authorisation required**	See note below		General Surgical - Breast
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 and either mammography or tissue pathology and the relevant documentation must be provided. In addition, the following conditions of payment must be satisfied in full; 1. Male >/=18 years 2. Post- pubertal 3. BMI <25 4. Unilateral of bilateral gyneacomastia 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). 5. Gynaecomastia that has been present for at least 1 year and has persisted despite treatment for at least 4 months for the underlying cause.				

Code	Description	Payment Rules	Payment Indicators	Speciality
1211	Gynaecomastia (excision for), bilateral. **Pre-authorisation required**	See note below		General Surgical - Breast
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 and either mammography or tissue pathology and the relevant documentation must be provided. In addition, the following conditions of payment must be satisfied in full; 1. Male >/=18 years 2. Post- pubertal 3. BMI <25 4. Unilateral of bilateral gyneacomastia 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). 5. Gynaecomastia that has been present for at least 1 year and has persisted despite treatment for at least 4 months for the underlying cause.				
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.)			General Surgical - Breast
1213	Mastectomy, partial,with or without guidance with axillary clearance, or removal of sentinel node(s) (I.P.)			General Surgical - Breast
1214	Mastectomy, partial, guided excision, for ductal carcinoma insitu (I.P.)		(I.P.)	General Surgical - Breast
1216	Mastectomy radical/ modified radical, with axillary clearance (IP)			General Surgical - Breast
1218	Mammographic wire guided breast biopsy		Diagnostic, Daycare	General Surgical - Breast
1219	Mastectomy and axillary clearance, immediate breast reconstruction with latissimus dorsi pedicle flap, with or without prosthetic implant or expanding prosthesis (I.P.)			General Surgical - Breast
1221	Mastectomy and axillary clearance, immediate breast reconstruction with extended latissimus dorsi pedicle flap (IP)			General Surgical - Breast
1222	Mastectomy, complete with or without removal of sentinel node(s) with immediate insertion of tissue expander, includes subsequent expansions (I.P.)		I.P.	General Surgical-Breast
1223	Mastectomy, partial, guided excision, with axillary sampling or removal of sentinel node(s), with immediate deep rotation flap reconstruction, with prosthetic implant			General Surgical-Breast
1250	Arterial biopsy (temporal artery, biopsy, bilateral under local anaesthetic)		Diagnostic, Side Room	Vascular
1280	Common femoral artery embolectomy			Vascular
1290	Ligation of major vessels			Vascular
1305	Renal stenosis, repair of			Vascular
1306	Transcatheter embolisation, extremity, arteriovenous malformation (AVM) (I.P.)		(I.P.)	Vascular
1307	Transcatheter removal of intravascular thrombus or foreign body			Vascular
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		Side Room	Vascular

Code	Description	Payment Rules	Payment Indicators	Speciality
1309	Fine needle aspiration (FNA), not otherwise specified in this Schedule, with or without preparation of smears; superficial or deep tissue with or without radiological guidance		Side Room	Skin & Subcutaneous Tissues
1310	Open superficial lymph node biopsy		Daycare	General Surgical - Lymphatics
1311	Biopsy or excision of lymph node(s); by needle, superficial (e.g. cervical, inguinal, axillary)		Side Room	General Surgical - Lymphatics
1314	Sentinel node biopsy with injection of dye and identification		Daycare	General Surgical - Lymphatics
1315	Axillary lymph nodes, complete dissection of			General Surgical - Lymphatics
1320	Axillary or inguinal lymph nodes, incision of abscess		Side Room, Service	General Surgical - Lymphatics
1326	Biopsy or excision of lymph node(s); open, deep cervical node(s)		Diagnostic, Daycare	General Surgical - Lymphatics
1335	Inguinal or pelvic lymph node block dissection, unilateral (I.P.)		(I.P.)	General Surgical - Lymphatics
1336	Inguinal or pelvic lymph node block dissection, bilateral (I.P.)		(I.P.)	General Surgical - Lymphatics
1365	Primary or secondary retroperitoneal, lymphadenectomy complete, transabdominal (I.P.)		(I.P.)	General Surgical - Lymphatics
1380	Muscle, repair and suture of			General Surgical - Muscle
1385	Muscle biopsy		Diagnostic, Side Room	General Surgical - Muscle
1390	Nerve biopsy		Diagnostic	General Surgical - Nerve
1395	Nerve repairs (primary) (I.P.)		(I.P.)	General Surgical - Nerve
1400	Nerve suture (secondary, including grafting and anastomosis)			General Surgical - Nerve
1401	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta			Vascular
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)			Vascular
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)			Vascular
1404	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, using aorto-aortic tube prosthesis			Vascular
1406	Neuroma, excision of		Daycare	General Surgical - Nerve

Code	Description	Payment Rules	Payment Indicators	Speciality
1407	Neurectomy			General Surgical - Nerve
1408	Ligation of perforator vein(s), subfacial, open, including ultrasound guidance (I.P.)		Independent Procedure	General Surgical-Vascular
1409	Aorta bi-iliac bypass for atherosclerosis or aneurysm; endovascular (using prosthesis) (I.P.)		Independent Procedure	General Surgical-Vascular
1410	Tendon repairs (primary), single			General Surgical - Tendons
1411	Endovenous radiofrequency ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; one leg		Daycare	Vascular
1412	Endovenous radiofrequency ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; both legs		Daycare	Vascular
1413	Endovenous laser ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; one leg	The treatment of spider/thread veins and telangiectasia are specifically excluded from benefit		Vascular
1414	Endovenous laser ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; both legs	The treatment of spider/thread veins and telangiectasia are specifically excluded from benefit		Vascular
1415	Tendon repairs (primary), multiple			General Surgical - Tendons
1416	Thrombin injection into groin for pseudoaneurysm (including ultrasound guidance)			Vascular
1419	Transluminal dilation of iliac vessels with or without stent or graft	For procedure codes 1419, 1421, 1422, 1423 and 1424 when angiography is performed by the interventional radiologist during the procedure this benefit is additional to the endovascular procedure benefit		Vascular - Endovascular
1420	Tendon sheath, incision of			General Surgical - Tendons
1421	Transluminal dilation with or without stent of carotid vessels	For procedure codes 1419, 1421, 1422, 1423 and 1424 when angiography is performed by the interventional radiologist during the procedure this benefit is additional to the endovascular procedure benefit		Vascular - Endovascular
1422	Transluminal dilation with or without stent or graft of femoral vessels	For procedure codes 1419, 1421, 1422, 1423 and 1424 when angiography is performed by the interventional radiologist during the procedure this benefit is additional to the endovascular procedure benefit		Vascular - Endovascular

Code	Description	Payment Rules	Payment Indicators	Speciality
1423	Transluminal dilation with stent of distal vessels	For procedure codes 1419, 1421, 1422, 1423 and 1424 when angiography is performed by the interventional radiologist during the procedure this benefit is additional to the endovascular procedure benefit		Vascular - Endovascular
1424	Transluminal dilation of distal vessels	For procedure codes 1419, 1421, 1422, 1423 and 1424 when angiography is performed by the interventional radiologist during the procedure this benefit is additional to the endovascular procedure benefit		Vascular - Endovascular
1425	Tenotomy			General Surgical - Tendons
1426	Tenolysis			General Surgical - Tendons
1427	Supra-renal aneurysm repair			Vascular
1428	Repair of supra-renal aortic aneurysm rupture			Vascular
1429	Tube graft repair of abdominal aorta			Vascular
1430	Iliac or femoral veins - removal of thrombus			Vascular
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 (IP)		(I.P.)	Vascular
1432	Aorto bi-iliac bypass for atherosclerosis or aneurysm (IP)		(I.P.)	Vascular
1433	Aorto-femoral or bifemoral bypass for atherosclerosis or aneurysm (IP)		(I.P.)	Vascular
1434	Endarterectomy of abdominal aorta and iliac vessels			Vascular
1435	Inferior vena cava ligation/ clipping, with or without thrombus			Vascular
1436	Repair of ruptured iliac artery aneurysm			Vascular
1437	Endarterectomy of iliac vessels alone			Vascular
1438	Visceral artery repair, re-anastomosis or endarterectomy			Vascular
1439	Renal artery anastomosis, endarterectomy or re-implantation or bypass			Vascular
1441	Embolectomy of visceral branches, superior mesenteric or renal arteries			Vascular
1442	Removal of infected aortic prosthesis			Vascular
1443	Obturator bypass from aorta or iliac to profunda or distal femoral bypass			Vascular
1444	Repair of abdominal aortic trauma			Vascular

Code	Description	Payment Rules	Payment Indicators	Speciality
1446	Aortic exclusion by axillo-femoral bypass			Vascular
1447	Endarterectomy of internal/external common carotid artery with or without patch graft with or without shunt			Vascular
1449	Vertebral artery bypass or repair			Vascular
1450	Portosystemic shunt			Vascular
1451	Open repair of subclavian artery			Vascular
1452	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis; autogenous or non-autogenous graft			Vascular
1453	Arteriovenous anastomosis, open by basilic vein transposition			Vascular
1454	Translocation of common carotid to subclavian artery			Vascular
1455	Sclerosing operation on varicose vein(s), one leg (I.P.)	The treatment of spider/thread veins and telangiectasia are specifically excluded from benefit	I.P., Side Room, Service	Vascular
1456	Carotid subclavian bypass			Vascular
1457	Subclavian/subclavian bypass			Vascular
1458	Thoracotomy with repair of vessels of arch of aorta			Vascular
1459	Subclavian to branchial bypass or endarterectomy			Vascular
1460	Sclerosing operation on varicose veins, both legs (I.P.)	The treatment of spider/thread veins and telangiectasia are specifically excluded from benefit	I.P., Side Room, Service	Vascular
1461	Repair of subclavian aneurysm			Vascular
1462	Brachial embolectomy			Vascular
1463	Repair or bypass of brachial to radial or ulnar vessel, any method including harvesting of graft material			Vascular
1464	Repair of trauma to brachial artery with endarterectomy patch or bypass			Vascular
1465	Splenorenal anastomosis			Vascular
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	Payable in full with code for main procedure	Vascular
1467	Femoral to popliteal bypass, above knee vein			Vascular
1468	Femoral to popliteal bypass, above knee synthetic			Vascular
1469	Femoral to popliteal bypass, below knee vein			Vascular
1471	Femoral to popliteal bypass, below knee synthetic			Vascular
1472	Profundaplasty with or without patch or endarterectomy			Vascular
1473	Common femoral artery endarterectomy			Vascular

Code	Description	Payment Rules	Payment Indicators	Speciality
1474	Repair of femoral artery aneurysm			Vascular
1476	Popliteal artery embolectomy			Vascular
1477	Tibial artery embolectomy			Vascular
1478	Femoral tibial artery bypass, including tibial-peroneal and peroneal artery bypass, or other distal vessels			Vascular
1479	Popliteal aneurysm artery repair or bypass			Vascular
1481	Femoral/femoral bypass			Vascular
1482	Repair of femoral or popliteal vessels due to trauma			Vascular
1490	Varicose veins, exploration and removal of thrombus, unilateral			Vascular
1491	Cockett, Linton or Dodd procedure on perforating veins (I.P.)		(I.P.)	Vascular
1493	Flush ligation of great saphenous vein at sapheno-femoral junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in leg; one leg	Max. 1 night Hospital Stay		Vascular
1494	Flush ligation of great 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	Max. 1 night Hospital Stay		Vascular
1495	Varicose veins, exploration and removal of thrombus, bilateral			Vascular
1496	Flush ligation of great saphenous vein at sapheno-femoral junction in the groin with or without complete stripping plus ligation of the small saphenous vein at the sapheno-popliteal junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in one leg	Documentation must be provided in order to support in competence of the short saphenous vein. The doppler scan report must therefore be attached to the claim form.		Vascular
1497	Flush ligation of great saphenous vein at sapheno-femoral junction in the groin with or without complete stripping plus ligation of the small saphenous vein at the sapheno-popliteal junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in both legs	Documentation must be provided in order to support in competence of the short saphenous vein. The doppler scan report must therefore be attached to the claim form.		Vascular
1498	Flush ligation of great saphenous vein at sapheno-femoral junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in the other leg	Max. 1 night Hospital Stay		Vascular
1499	Flush ligation of small 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	Max. 1 night Hospital Stay		Vascular
1500	Venous pressure and blood volume studies		Diagnostic	Vascular
1501	Flush ligation of small 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			Vascular

Code	Description	Payment Rules	Payment Indicators	Speciality
1502	Ligation of single varicose vein in thigh or calf (I.P.)		(I.P.) , Side Room	Vascular
1503	Ligation of multiple varicose veins one or both legs (I.P.)	Max. 1 night Hospital Stay	I.P.	Vascular
1507	Angioma of skin and subcutaneous tissue or mucous surfaces, excision and repair of, under general anaesthetic		Daycare	Skin & Subcutaneous Tissues
1509	Biopsy of skin, subcutaneous tissue and/or mucous membrane including simple closure (I.P.)		(I.P.) , Side Room, Service, Private Rooms	Skin & Subcutaneous Tissues
1526	Stab avulsion of varicose vein(s), one leg (I.P.)		(I.P.) , Daycare	Vascular
1527	Stab avulsion of varicose vein(s), both legs (I.P.)		(I.P.) , Daycare	Vascular
1528	Patch Testing - Consultant Dermatologist or Immunologist consultations on an out-patient basis, for the application and/ or supervising of patch testing, for contact dermatitis or atopic eczema (including testing with additional series and prick testing when indicated), interpretation and diagnosis, clinical evaluation and judgement including advice to patient (claimable once only in a lifetime)		Service	Skin & Subcutaneous Tissues
1529	Phototherapy - Consultant Dermatologist consultations on an out-patient basis for a patient receiving a course of phototherapy in an Aviva approved hospital facility (list available on request from Aviva). For procedure code 1529 maximum benefit of one payment per twelve month period		Side Room, Service	Skin & Subcutaneous Tissues
1531	Biopsies of the skin, subcutaneous tissue and/or mucous membrane including simple closure (I.P.) (the areas biopsied must be specified on the claim form)		Side Room Only Service I.P.	General Surgical - Skin & Subcutaneous Tissues
1550	Malignant melanoma, wide excisional biopsy	A copy of the histology report for all claims for this procedure must be included with the claim, Side Room		Skin & Subcutaneous Tissues
1551	Malignant melanoma, wide excisional biopsy and graft to include wide excision with flap or graft	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		Skin & Subcutaneous Tissues
1560	Incision and drainage of pilonidal abscess			Skin & Subcutaneous Tissues
1561	Pilonidal sinus or cyst, excision of	Max. 1 night Hospital Stay		Skin & Subcutaneous Tissues
1562	Pilonidal Sinus, excision of, with Rhomboid flap/Z-plasty for closure of large defect; multiple layer closure			Skin & Subcutaneous Tissues

Code	Description	Payment Rules	Payment Indicators	Speciality
1571	Intravenous infusion of ferinject (ferric carboxymaltose) for patients with resistant iron deficiency anaemia (maximum of two treatments per year)	See note below	Side Room	Skin & Subcutaneous Tissues
NOTE: 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 is payable. This code may only be claimed when performed in a Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given				
1572	Intravenous infusion of Monover (iron isomaltoside) for patients with resistant iron deficiency anaemia	See note below	Side Room	Skin & Subcutaneous Tissues
NOTE: 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 is payable. This code may only be claimed when performed in a Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given				
1573	Removal of intraport venous access for chemotherapy under local anaesthetic sedation		Side Room Only	Other Procedures & Services
1574	Subcutaneously placed central venous access port (e.g., Portaacath) with tunnelled catheter for the administration of chemotherapy (I.P.) see note	See note below	Side Room Only I.P.	Other Procedures & Services
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.				
1575	Basal cell carcinoma/squamous cell carcinoma, malignant tumour - simple excision	A copy of the histology report for all claims for this procedure must be included with the claim		Skin & Subcutaneous Tissues
1576	Basal cell carcinoma/squamous cell carcinoma, malignant tumour -excision and graft or local flap	See note below	Daycare, Service	Skin & Subcutaneous Tissues
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. If an earlier Code 1575 was performed within 6 weeks and the histology report confirmed BCC or SCC, then Code 1576 may be claimed for the second procedure when repair is carried out in accordance with the description in 1576, with or without additional marginal excision - a copy of the histology report is required				
1578	Wounds, lacerations or ulcers requiring debridement when it is medically necessary to perform the procedure under general anaesthetic (I.P.)		Daycare, Service, Independent Procedure	Other Procedures & Services - Wounds
1579	Consultation and assessment of a patient commencing, or during the course of, intravenous cytotoxic chemotherapy, where the patient also receives an infusion of pamidronate (aredia), or zoledronic acid (zometa), for patients with metastatic carcinoma		Side Room	Skin & Subcutaneous Tissues

Code	Description	Payment Rules	Payment Indicators	Speciality
1581	Mohs micrographic technique, including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the Consultant, head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves or vessels; first layer (stage) up to five tissue blocks. (If the tissue layer is large enough that it must be cut into six or more specimens producing six or more blocks of tissue in order to examine the entire surgical margin, then use code 1596 for each block beyond the first five)	Moh's micrographic surgery - please refer to Surgical Note 29 on page 50		Skin & Subcutaneous Tissues
1582	Each additional layer (stage) after the first layer (stage), up to 5 tissue blocks	Moh's micrographic surgery - please refer to Surgical Note 29 on page 50		Skin & Subcutaneous Tissues
1583	Mohs micrographic technique, including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the Consultant, of the trunk, arms, or legs; first layer (stage), up to 5 tissue blocks.	Moh's micrographic surgery - please refer to Surgical Note 29 on page 50		Skin & Subcutaneous Tissues
1584	Each additional layer (stage) after the first layer (stage), up to 5 tissue blocks	Moh's micrographic surgery - please refer to Surgical Note 29 on page 50		Skin & Subcutaneous Tissues
1587	Laser treatment to port wine stains only, one or more sessions, , patients aged under 16, plus photographic evidence to be supplied with claim	Outpatient, Consultant Fee remains direct settlement		Skin & Subcutaneous Tissues
15871	Laser treatment to port wine stains only, one or more sessions, patients aged under 16, under General Anaesthesia, plus Photographs		Day Case	Skin & Subcutaneous Tissues
1588	Excision of axillary skin for hyperhidrosis **Pre authorisation**			Skin & Subcutaneous Tissues
1591	Hydradenitis suppurativa, excision and suture		Side Room	Skin & Subcutaneous Tissues
1592	Hydradenitis suppurativa, excision and graft			Skin & Subcutaneous Tissues
1593	Hydradenitis suppurativa, extensive debridement		Daycare	Skin & Subcutaneous Tissues
1594	Infusion of tocilizumab (RoActemra)	See note below	Side Room	Skin & Subcutaneous Tissues
Treatment of moderate rheumatoid arthritis; a) In combination with methotrexate b) As monotherapy in case of intolerance methotrexate or continued treatment with methotrexate is inappropriate c) In adult patients who have either responded inadequately to, or who were intolerant to, previous therapy with one or more disease modifying anti-rheumatic drugs or tumour necrosis factor antagonists 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.				

Code	Description	Payment Rules	Payment Indicators	Speciality
1596	Mohs micrographic technique, including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the Consultant, each additional block after the first 5 tissue blocks, any layer (stage), (Benefit is payable in full in conjunction with 1581 to 1584) **Pre-authorisation required**	Moh's micrographic surgery - please refer to Surgical Note 29 on page 50	Side Room Pre-authorisation required	Skin & Subcutaneous Tissues
1597	Repair closure associated with Mohs surgery, head and neck, all sizes	Moh's micrographic surgery - please refer to Surgical Note 29 on page 50	Side Room	Skin & Subcutaneous Tissues
1598	Repair closure associated with Mohs surgery, non-head and neck, all sizes	Moh's micrographic surgery - please refer to Surgical Note 29 on page 50	Side Room	Skin & Subcutaneous Tissues
1599	Adjustment 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	Moh's micrographic surgery - please refer to Surgical Note 29 on page 50	Side Room	Skin & Subcutaneous Tissues
1603	Wounds greater than 7.5cm in total length, suture of with one layer repair of the epidermis, dermis or subcutaneous tissues with suture	Benefit includes wound closure by tissue adhesives' (e.g. 2-cyanocrylate) 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 not be claimed	Side Room	Skin & Subcutaneous Tissues
1604	Adjustment 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	Moh's micrographic surgery - please refer to Surgical Note 29 on page 50		Skin & Subcutaneous Tissues
1606	Intravenous infusion of zoledronic acid (aclasta) for treatment of osteoporosis in post menopausal women and men at increased risk of fracture including those with a recent low trauma hip fracture, who fail to tolerate oral bisphosphonates	Maximum benefit of one payment per twelve months, for a period of three years 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	Side Room	Skin & Subcutaneous Tissues
1607	Intravenous infusion of Abatecept with methotrexate for the treatment of moderate to severe rheumatoid arthritis in adult patients who have had an insufficient response or intolerance to other disease-modifying anti-rheumatic drugs including at least one tumour necrosis factor (TNF) inhibitor	See note below	Side Room	Skin & Subcutaneous Tissues
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. Only claimable when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given				

Code	Description	Payment Rules	Payment Indicators	Speciality
1608	Emergency assessment of a patient on a course of chemotherapy where a decision is made, due to a medical problem, not to proceed with planned chemotherapy that day and may require further radiological and/or pathological tests before discharge		Side Room, Service	Skin & Subcutaneous Tissues
1609	Consultant Medical Oncologist out-patient consultation and assessment of a patient on a course of cytotoxic oral cancer drugs.	Maximum one per three weekly interval. The oral drug must be named on the claim form. Outpatient Only. Cannot be charged in conjunction with codes 1607,1611,1613,1623,1637,1641,1668,1669		Skin & Subcutaneous Tissues
1611	Intravenous infusion of Fabrazyme for patients with a confirmed diagnosis of Fabry's disease	See note below	Side Room, Service	Skin & Subcutaneous Tissues
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. Only claimable when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given				
1613	Intravenous infusion therapy for severe neurtologial disorders or auto-immune disease, not elsewhere specified and for Hurler's and Hunter's disease; by Consultant Neurologists, Immunologists, Rheumatologists, Haematologists, Nephrologists, Paediatricians and Respiratory Physicians registered with Aviva	See note below	Side Room, Service	Skin & Subcutaneous Tissues
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. Only claimable when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given				
1614	Infusion of Mitozantrone (Novantrone) for patients with secondary progressive multiple sclerosis, progressive-relapsing multiple sclerosis and worsening relapsing-remitting multiple sclerosis	See note below	Side Room, Service	Skin & Subcutaneous Tissues
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. Only claimable when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given				

Code	Description	Payment Rules	Payment Indicators	Speciality
1619	Intravenous Cytotoxic Chemotherapy	See note below	Side Room, Service	Skin & Subcutaneous Tissues
The following consultant consultation is payable when one of the following conditions is satisfied: 1) Initial consultation with a new patient commencing a cycle of intravenous cytotoxic chemotherapy 2) Major consultation and reassessment of a patient commencing a new cycle of intravenous cytotoxic chemotherapy 3) Consultation and assessment of a patient on day 8, 15 and 22 during a cycle of intravenous cytotoxic chemotherapy 4) Consultation and assessment of a patient during the course of intravenous cytotoxic chemotherapy given on successive days in any week (days 2 to 7 inclusive), in these circumstances benefit can only be claimed for one additional assessment during the week's course of treatment. i.e. a total of 2 charges per week as a maximum The consultation includes examination and assessment of the patient, patient and family counselling (if required), psychological support for the patient, evaluation of all necessary diagnostic tests, prescription, checking and supervision of chemotherapy administration and management of any immediate adverse effects which may arise. NOTE: Where it is medically necessary for a patient to be admitted to hospital as an inpatient, irrespective of cell type (histology) and undergoes in-patient evaluation, cytotoxic chemotherapy planning and delivery, only the in-patient attendance benefit is payable. Definitions: Course: a course refers to a prescribed regimen of cytotoxic chemotherapy to be delivered in a specified number of cycles over a defined period of time which usually lasts for 3 - 9 months depending on the disease being treated. Cycle: a cycle refers to a repeated regimen of treatment given at a specified interval which is dictated by the outcome of clinical trials which have established optimal scheduling in the light of efficacy and patients tolerance. The usual cycle is 21 - 28 days with treatment potentially given on (i) Day 1 only (ii) days 1 - 7 inclusive or less (iii) days 1 and 8; (iv) days one and 15 (v) days 1, 8, 15, 22 (vi) other.Side Room. Cannot be charged in conjunction with codes 1607,1611,1613,1623,1637,1641,1668,1669				
16191	Sub-cutaneous Cytotoxic Chemotherapy	See note below	Service, Side Room	Skin & Subcutaneous Tissues
The following consultant consultation is payable when one of the following conditions is satisfied: 1) Initial consultation with a new patient commencing a cycle of Sub-cutaneous cytotoxic chemotherapy 2) Major consultation and reassessment of a patient commencing a new cycle of Sub-cutaneous cytotoxic chemotherapy 3) Consultation and assessment of a patient on day 8, 15 and 22 during a cycle of Sub-cutaneous cytotoxic chemotherapy 4) Consultation and assessment of a patient during the course of Sub-cutaneous cytotoxic chemotherapy given on successive days in any week (days 2 to 7 inclusive), in these circumstances benefit can only be claimed for one additional assessment during the week's course of treatment. i.e. a total of 2 charges per week as a maximum The consultation includes examination and assessment of the patient, patient and family counselling (if required), psychological support for the patient, evaluation of all necessary diagnostic tests, prescription, checking and supervision of chemotherapy administration and management of any immediate adverse effects which may arise. Definitions: Course: a course refers to a prescribed regimen of cytotoxic chemotherapy to be delivered in a specified number of cycles over a defined period of time which usually lasts for 3 - 9 months depending on the disease being treated. Cycle: a cycle refers to a repeated regimen of treatment given at a specified interval which is dictated by the outcome of clinical trials which have established optimal scheduling in the light of efficacy and patients tolerance. Cannot be charged in conjunction with codes 1607,1611,1613,1623,1637,1641,1668,1669				
16192	Oral Cytotoxic Chemotherapy	See note below	Service, Side Room	Skin & Subcutaneous Tissues
The following consultant consultation is payable when one of the following conditions is satisfied: 1) Initial consultation with a new patient commencing a cycle of Oral cytotoxic chemotherapy 2) Major consultation and reassessment of a patient commencing a new cycle of Oral cytotoxic chemotherapy 3) Consultation and assessment of a patient on day 8, 15 and 22 during a cycle of Oral cytotoxic chemotherapy 4) Consultation and assessment of a patient during the course of Oral cytotoxic chemotherapy given on successive days in any week (days 2 to 7 inclusive), in these circumstances benefit can only be claimed for one additional assessment during the week's course of treatment. i.e. a total of 2 charges per week as a maximum The consultation includes examination and assessment of the patient, patient and family counselling (if required), psychological support for the patient, evaluation of all necessary diagnostic tests, prescription, checking and supervision of chemotherapy administration and management of any immediate adverse effects which may arise. NOTE: The administration of Oral Chemotherapy is covered by Aviva on the understanding that the administration and Consultant input is similar to that process and inputs as set out in code 1619. Definitions: Course: a course refers to a prescribed regimen of cytotoxic chemotherapy to be delivered in a specified number of cycles over a defined period of time which usually lasts for 3 - 9 months depending on the disease being treated. Cycle: a cycle refers to a repeated regimen of treatment given at a specified interval which is dictated by the outcome of clinical trials which have established optimal scheduling in the light of efficacy and patients tolerance. The usual cycle is 21 - 28 days with treatment potentially given on (i) Day 1 only (ii) days 1 - 7 inclusive or less (iii) days 1 and 8; (iv) days one and 15 (v) days 1, 8, 15, 22 (vi) other.Side Room. Cannot be charged in conjunction with codes 1607,1611 ,1613,1623,1637,1641,1668,1669				

Code	Description	Payment Rules	Payment Indicators	Speciality
1623	Intravenous immunoglobulin for patients with myasthenia gravis, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy with conduction block and Guillain-Barre syndrome	See note below	Side Room	Skin & Subcutaneous Tissues
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. Only claimable when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given				
1624	Intravenous infusion of zoledronic acid (zometa) for pagets disease; pain control for patients with metastatic carcinoma or melanoma; prevention of skelatel related events in patients with advanced malignancies of involving bone; tumour induced hypercalcemia	See note below	Side Room	Skin & Subcutaneous Tissues
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. Only claimable when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given				
1626	Tunnelled central venous access or tunnelled translunbar venuous access with externalized catheter end	See note below		Skin & Subcutaneous Tissues
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. 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.				
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.)	See note below	I.P. Daycare	Skin & Subcutaneous Tissues
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.				
1628	Insertion of tunnelled central line for total parenteral nutrition only (I.P.)	See note below	I.P. Sideroom	Skin & Subcutaneous Tissues
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.				

Code	Description	Payment Rules	Payment Indicators	Speciality
1629	Intravenous infusion of pamidronate (aredia) for: pain control for patients with metastatic carcinoma; tumour induced osteolysis with or without tumour induced hypercalcemia; paget-S disease	See note below	Side Room	Skin & Subcutaneous Tissues
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. Only claimable when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given				
1630	Exchange transfusion, blood; newborn			Skin & Subcutaneous Tissues
1631	Hyperbaric oxygen therapy, initial, including full medical evaluation Conditions of payment are as follows: - Air or gas embolism - Carbon monoxide poisoning and smoke inhalation - Crush injury compartment syndrome and other acute traumatic ischaemias - Decompression illness - Exceptional blood loss anaemia - Osteomyelitis - Radiation damage - Skin grafts and compromised flaps - Thermo burns			Skin & Subcutaneous Tissues
1632	Hyperbaric oxygen therapy, subsequent, per session Conditions of payment are as follows: - Air or gas embolism - Carbon monoxide poisoning and smoke inhalation - Crush injury compartment syndrome and other acute traumatic ischaemias - Decompression illness - Exceptional blood loss anaemia - Osteomyelitis - Radiation damage - Skin grafts and compromised flaps - Thermo burns			Skin & Subcutaneous Tissues
1633	Infusion of infliximab(Remicade)	See note below	Side Room	Skin & Subcutaneous Tissues
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. The following indications will apply: Crohn's Disease - Treatment of severe active Crohn's disease where patients have not responded despite a full and adequate course of therapy with a cortico-steroid and/or an immuno-suppressant. - Treatment of fistulating Crohn's disease in patients who have not responded despite a full and adequate course of therapy with conventional treatment. Rheumatoid Arthritis The patients for whom benefit will apply are those over seventeen years of age with active disease. Benefit will be provided only when the drug is consultant prescribed and used as indicated below: - Benefit for an initial three infusions at 0, 2 and 6 weeks and repeated administration of one infusion every eight weeks will apply where indicated for Rheumatoid Arthritis - The reduction of signs and symptoms in patients with active disease when the response to disease modifying drugs, including methotrexate, has been inadequate - Infliximab (Remicade) must be given concomitantly with methotrexate - Patients with severe active and progressive disease not previously treated with methotrexate or other DMARD's (Disease Modifying Anti-Rheumatic Drug Therapy) Ankylosing Spondylitis Treatment of anklyosing spondylitis, in patients who have severe axial symptoms, elevated serological markers of inflammatory activity and who have responded inadequately to conventional therapy. Psoriatic Arthritis Treatment of active and progressive psoriatic arthritis in adults when the response to previous DMARD's has been inadequate. Infliximab (Remicade) should be administered in combination with methotrexate or alone in patients who show intolerance to methotrexate or for whom methotrexate is contraindicated. Psoriasis Treatment of moderate to severe plaque psoriasis in adults who have failed to respond to or have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, methotrexate or PUVA.			
1634	Placement of central venous catheter (peripherally or centrally inserted) for chemotherapy, TPN or long-term antibiotic therapy (I.P.)	See note below	I.P. , Side Room, Monitored Anaesthesia Care	Skin & Subcutaneous Tissues
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.				

Code	Description	Payment Rules	Payment Indicators	Speciality
1635	Exchange transfusion (intra uterine)			Skin & Subcutaneous Tissues
1636	Intravenous immunoglobulin for patients with a haematological malignancy or immune deficiencies	See note below	Side Room	Skin & Subcutaneous Tissues
For procedure codes 1594, 1606, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, 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. For infusion procedures 55, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, codes may only be claimed when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given.				
1637	Blood transfusion for patients with a haematological malignancy or immune deficiencies	See note below	Side Room	Skin & Subcutaneous Tissues
NOTE: for procedure codes 1594, 1606, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, 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. For infusion procedures 55, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, codes may only be claimed when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given.				
1638	Intravenous antibiotics for patients on cytotoxic chemotherapy regimens for malignant disease	See note below	Side Room	Skin & Subcutaneous Tissues
NOTE: for procedure codes 1594, 1606, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, 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. For infusion procedures 55, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, codes may only be claimed when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given.				
1639	Electrolyte replacement for patients on cytotoxic chemotherapy regimens for malignant disease	See note below	Side Room	Skin & Subcutaneous Tissues
NOTE: for procedure codes 1594, 1606, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, 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. For infusion procedures 55, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, codes may only be claimed when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given.				
1642	Isolated limb perfusion including exposure of major limb artery and vein, arteriotomy and venotomy			Skin & Subcutaneous Tissues
1643	Intravenous iron infusion for patients with resistant iron deficiency anaemia	See note below	Side Room	Skin & Subcutaneous Tissues
NOTE: for procedure codes 1594, 1606, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, 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. For infusion procedures 55, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, codes may only be claimed when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given.				
1646	Plasmapheresis		Side Room	Skin & Subcutaneous Tissues

Code	Description	Payment Rules	Payment Indicators	Speciality
1663	Drainage of abscess or haematoma, (deep tissues) requiring general anaesthetic			Skin & Subcutaneous Tissues
1664	Insulin stress test (IST) to include initial consultation for a new patient or major reassessment of an established patient, in addition intravenous administration of insulin, sampling for basal level setting and all necessary sampling and monitoring of the patient during the procedure (I.P.)		(I.P.) , Daycare, Service	Skin & Subcutaneous Tissues
1665	Atresia of auricle, 2 or 3 stages, correction of (per stage) (I.P.)		(I.P.)	Ear, Nose & Throat
1666	Attico antrostomy, unilateral			Ear, Nose & Throat
1667	Aspirin desensitisation, to include all necessary sampling and monitoring of the patient during the procedure	See note below	Daycare, Service	Ear, Nose & Throat
Benefit allowable for each desensitisation procedure . Benefit for procedure code 1667 is payable only for those patients who have been identified as having a positive aspirin challange following investigations carried out under the procedure code 5985				
1668	Infusion of MabThera with methotrexate for the treatment of adult patients with severe active rheumatoid arthritis who have had an inadequate response or intolerance to other disease-modifying anti-rheumatic drugs including one or more tumour necrosis factor (TNF) inhibitor therapies	See note below	Side Room	Ear, Nose & Throat
NOTE: for procedure codes 1594, 1606, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, 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. For infusion procedures 55, 1607, 1611, 1613, 1614, 1623, 1624, 1629, 1636, 1633, 1637, 1638, 1639, 1643, 1668, 1669, codes may only be claimed when performed in an Aviva approved facility. The consultants providing the infusion service must be registered with Aviva in the specialty associated with the disease type that is the subject of the infusion. The hospital facility and the Consultant must provide the full spectrum of medical services associated with the disease entity that is the subject of the infusion given				
1669	Infusion of Tysabri as a single disease modifying therapy in highly active relapsing remitting multiple sclerosis **Pre-authorisation required**	See note below	Side Room	Ear, Nose & Throat
Benefit is payable only for the following categories of patients who are aged under 65 years: Patients with high disease activity despite treatment with beta-interferon or patients with rapidly evolving severe relapsing remitting multiple sclerosis. The procedure is subject to pre-certification for the initial infusion and, if approved, benefit will be payable for a maximum of six monthly infusions. If treatment is to be continued beyond six months pre-certification is again required and benefit will only be payable in patients who show evidence of therapeutic benefit. Where benefit is approved beyond six months the benefit will be provided initially for a maximum of two years. If treatment is to be continued beyond two years, benefit will be provided for a maximum of three years for patients enrolled in the TYGRIS (TYsabri Global obseRvation program In Safety) study. We will consider benefit beyond 2 years for other members who are not enrolled in this study, provided similar documentation to that collected as part of the TYGRIS study is collected on a pilot basis.				
1670	Excision/repair external ear; soft tissue lesion(s), polyp/polyi or repair of split ear lobe(s) or other trauma, one or both ears		Side Room	Ear, Nose & Throat
1671	Debridement, ear canal and/or mastoidectomy cavity, complex 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.)		(I.P.) , Side Room, Service	Ear, Nose & Throat
1672	Labyrinthotomy, with or without cryosurgery including other non excisional destructive procedures or perfusion of vestibuloactive drugs, single perfusion, transcanal		Side Room	Ear, Nose & Throat

Code	Description	Payment Rules	Payment Indicators	Speciality
1673	Endocrine assessment of pituitary function, following pituitary surgery, to include initial consultation and assessment of the hypothalamic pituitary adrenal access, with or without free thyroxine testing and testosterone/estradiol testing and all necessary sampling and monitoring of a patient during the procedure	Max 1 night Hospital Stay		Ear, Nose & Throat
1675	Drainage external ear, abscess or haematoma		Daycare	Ear, Nose & Throat
1677	Administration of cytotoxic chemotherapy (Vidaza) by subcutaneous injection requiring monitoring in a hospital setting		Side Room	Skin & Subcutaneous Tissues
1680	External auditory canal, excision of tumour		Daycare	Ear, Nose & Throat
1685	External auditory canal, removal of exostosis or osteoma			Ear, Nose & Throat
1686	External auditory canal, reconstruction of (meatoplasty) (e.g. for stenosis due to trauma, infection) (I.P.)		(I.P.) , Daycare	Ear, Nose & Throat
1690	Facial nerve decompression (in temporal bone)			Ear, Nose & Throat
1695	Facial nerve graft (in temporal bone)			Ear, Nose & Throat
1700	Foreign body, removal from ear, under general anaesthetic (I.P.)		(I.P.) , Daycare	Ear, Nose & Throat
1701	Labyrinthectomy; transcanal			Ear, Nose & Throat
1710	Mastoidectomy, radical with or without labyrinthectomy			Ear, Nose & Throat
1715	Mastoidectomy, simple			Ear, Nose & Throat
1730	Myringoplasty, surgery confined to drumhead and donor area (not for the removal of myringotomy tubes) (I.P.)		(I.P.)	Ear, Nose & Throat
1735	Myringotomy, unilateral		Daycare	Ear, Nose & Throat
1740	Myringotomy, bilateral		Daycare	Ear, Nose & Throat
1741	Removal of drain tube(s) under general anaesthetic		Daycare	Ear, Nose & Throat
1745	Nostril closure, for atrophic rhinitis			Ear, Nose & Throat
30120	Rhinophyma (I.P.) **pre-authorisation required**	Supported by a Consultant report and photographic evidence	(I.P.)	Plastic Surgery
1751	Pinna, total excision			Ear, Nose & Throat
1752	Pinna, partial excision with flap reconstruction		Daycare	Ear, Nose & Throat
1753	Pinna, partial excision and graft		Daycare	Ear, Nose & Throat
1755	Preauricular sinus, excision of		Daycare	Ear, Nose & Throat
1760	Saccus endolymphaticus for Meniere's Disease			Ear, Nose & Throat
1770	Stapedectomy			Ear, Nose & Throat
1771	Stapedectomy with plastic reconstruction of ossicles			Ear, Nose & Throat
1785	Myringotomy with insertion of grommet		Daycare	Ear, Nose & Throat
1786	Myringotomy, bilateral, with insertion of grommets		Daycare	Ear, Nose & Throat

Code	Description	Payment Rules	Payment Indicators	Speciality
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.)		(I.P.) , Daycare	Ear, Nose & Throat
1790	Tympanoplasty (I.P.)	Max 1 night Hospital Stay	I.P.	Ear, Nose & Throat
1805	Epistaxis - posterior - anterior packing and/or cautery (I.P.)		(I.P.) , Daycare	Ear, Nose & Throat
1810	Epistaxis, anterior ethmoid and/or internal maxillary ligation (I.P.)		(I.P.)	Ear, Nose & Throat
1815	Foreign body, removal from nose, under general anaesthetic		Daycare	Ear, Nose & Throat
1820	Polypectomy, single (I.P.)		(I.P.) , Daycare	Ear, Nose & Throat
1825	Polypectomy, multiple (I.P.)		(I.P.) , Daycare	Ear, Nose & Throat
1830	Accessory sinuses, open operations on, unilateral (including Caldwell Luc)			Ear, Nose & Throat
1840	Accessory sinuses, open operations on, bilateral (including Caldwell Luc)			Ear, Nose & Throat
1850	Antral biopsy		Diagnostic	Ear, Nose & Throat
1855	Antral puncture (antrotomy) and washout unilateral (I.P.)		(I.P.) , Side Room	Ear, Nose & Throat
1860	Antral puncture (antrotomy) and washout bilateral (I.P.)		(I.P.) , Daycare	Ear, Nose & Throat
1875	Sinusotomy with or without biopsy, with mucosal stripping or removal of polyp(s)			Ear, Nose & Throat
1879	Nasal/sinus endoscopy, surgical, with control of nasal haemorrhage (I.P.)		(I.P.)	Ear, Nose & Throat
1880	Nasal/Sinus endoscopy, surgical, with antrostomy, unilateral	Max 1 night Hospital Stay		Ear, Nose & Throat
1885	Nasal/Sinus endoscopy, surgical, with antrostomy, bilateral	Max 1 night Hospital Stay		Ear, Nose & Throat
1890	Repair of choanal atresia, intranasal			Ear, Nose & Throat
1895	Repair of choanal atresia, transpalatine			Ear, Nose & Throat
1896	Crawford tube insertion, unilateral			Ear, Nose & Throat
1897	Crawford tube insertion, bilateral			Ear, Nose & Throat
1900	Ethmoid area, malignant tumour excision			Ear, Nose & Throat
1904	Nasal/sinus endoscopy, diagnostic, unilateral or bilateral (I.P.)		(I.P.) , Diagnostic, Side Room	Ear, Nose & Throat
1905	Nasal/Sinus endoscopy, surgical; with biopsy, polypectomy or removal of diseased mucosa, lesions or debridement (I.P.)		(I.P.) , Diagnostic, Side Room	Ear, Nose & Throat
1910	Ethmoidectomy, extranasal, unilateral			Ear, Nose & Throat

Code	Description	Payment Rules	Payment Indicators	Speciality
1915	Ethmoidectomy, extranasal, bilateral			Ear, Nose & Throat
1920	Ethmoidectomy, intranasal, unilateral	Max 1 night Hospital Stay		Ear, Nose & Throat
1925	Ethmoidectomy, intranasal, bilateral (includes Code 1992)	Includes Code 1992 and Max 1 night Hospital Stay		Ear, Nose & Throat
1935	External frontal sinus exploration			Ear, Nose & Throat
1940	External frontal sinus operation for malignant disease			Ear, Nose & Throat
1945	External rhinotomy (with drainage of ethmoid frontal, or maxillary sinuses)			Ear, Nose & Throat
1968	Nasal septum, insertion of prosthetic button		Daycare	Ear, Nose & Throat
1969	Plastic repair of nasal septum	Max 1 night Hospital Stay		Ear, Nose & Throat
1970	Nasal septum, submucous resection of			Ear, Nose & Throat
1980	Naso pharyngeal tumour, excision of			Ear, Nose & Throat
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)		Daycare	Ear, Nose & Throat
1990	Cauterisation and/or ablation, mucous of turbinates, unilateral or bilateral, any method, superficial (I.P.)		(I.P.) , Daycare	Ear, Nose & Throat
1992	Nasal/Sinus endoscopy, surgical with ethmoidectomy (partial or total)	Max 1 night Hospital Stay		Ear, Nose & Throat
1993	Nasal/Sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus, including ethmoidectomy and/or nasal sinus endoscopy	Max 1 night Hospital Stay. A copy of CT scan must be made available when requested, to include for purposes of clarifcation Code 1922 and/or Code 1925		Ear, Nose & Throat
1994	Bronchoscopy; diagnostic, with or without bronchoalveolar lavage, cell washing or brushing, bronchial biopsy (I.P.)		(I.P.) , Diagnostic, Side Room	Ear, Nose & Throat
1995	Abscess (retropharyngeal), incision and drainage (internal pharyngotomy)			Ear, Nose & Throat
1999	Bronchoscopy with laser ablation/ resection of tumour (I.P.)		(I.P.)	Ear, Nose & Throat
2004	Bronchoscopy; diagnostic, with or without cell washing or brushing, with transbronchial and/or transthoracic biopsy, (with or without fluoroscopic guidance) with or without endobronchial ultrsound (EBUS) guided transmural biopsy (S) of tumours or lymph nodes (I.P.)		(I.P.) , Diagnostic, Daycare, Monitored Anaesthesia Care	Ear, Nose & Throat

Code	Description	Payment Rules	Payment Indicators	Speciality
2005	Bronchoscopy with bronchoalveolar lavage, includes the sequential instillation and recovery of aloquotes of fluids via bronchoscope wedged in a segmental bronchus with or without biopsy (I.P.)	See note below	I.P. , Diagnostic, Daycare, Monitored Anaesthesia Care	Ear, Nose & Throat
Benefit is payable in the following circumstances only: (1) when a definitive diagnosis has already been made and this procedure is required to monitor the patient during treatment. Bronchoalveolar lavage required for diagnosis is provided for in procedure 1994.(2) for patients with non-infectious immunological lung disease; (3) for suspected pulmonary infection in immunocompromised patients. All claims must be supported by a full comprehensive medical report from the consultant physician outlining the necessity for performing this procedure. This benefit is not payable for patients with pulmonary fibrosis consistent with replacement fibrosis ie. when the fibrosis tissue replaces lung parenchyma damaged by infection or by some other destructive process.				
2006	Bronchoscopic biopsy of peripheral pulmonary nodule under fluroscopic guidance (I.P.)		(I.P.) , Diagnostic, Daycare, Monitored Anaesthesia Care	Ear, Nose & Throat
2007	Inhalation bronchial challenge with histamine, methacholine, or similar compounds(IP)		(I.P.) , Side Room	Ear, Nose & Throat
2012	Bronchoscopy with or without bronchial biopsy(I.P.)	Benefit is claimable for patients less than 2 years old only	I.P. , Diagnostic	Ear, Nose & Throat
2013	Bronchoscopy; diagnostic, (rigid), with or without biopsy (I.P.)		(I.P.) , Diagnostic, Daycare	Ear, Nose & Throat
2014	Bronchoscopy and airway evaluation in patients with suspected (on the basis of severe sleep disturbance) or proven sleep apnoea (I.P.)		(I.P.) , Diagnostic, Daycare	Ear, Nose & Throat
2020	Bronchoscopy with removal of foreign body (includes foreign body removal by rigid endoscopy) (I.P.)		(I.P.) , Diagnostic	Ear, Nose & Throat
2030	Laryngoscopy (I.P.)		(I.P.) , Diagnostic, Side Room, Service	Ear, Nose & Throat
2031	Laryngoscopy, direct, operative with biopsy (I.P.)		(I.P.) , Daycare, Service	Ear, Nose & Throat
2032	Laryngoscopy, direct, with or without tracheostomy, with dilatation (I.P.)		(I.P.) , Daycare, Service	Ear, Nose & Throat
2040	Laryngectomy, all forms including vertical hemi laryngectomy and tracheostomy			Ear, Nose & Throat
2050	Laryngofissure, external operation on			Ear, Nose & Throat
2051	Laryngoplasty, (type 1 thyroplasty) including transcervical placement of an implant (e.g. for burns, reconstruction after partial laryngectomy or post thyroid surgery			Ear, Nose & Throat

Code	Description	Payment Rules	Payment Indicators	Speciality
2053	Aryepiglottoplasty for the management of laryngomalacia in a multi-disciplinary team approach to care for a child under one year of age			Ear Nose & Throat - Throat
2054	Microsurgery with CO2 laser for the complete removal of laryngeal cancer			Ear, Nose & Throat
2055	Lateral pharyngotomy			Ear, Nose & Throat
2056	Microsurgery of larynx with complete removal of benign or malignant lesions (not for biopsy of lesions - code 2031) (I.P.)		(I.P.) , Daycare	Ear, Nose & Throat
2057	Vocal cord augmentation (injection of teflon)			Ear, Nose & Throat
2058	Botulinum toxin injections for laryngeal dysphonia		Daycare, Service	Ear, Nose & Throat
2060	Oesphagoscopy flexible, with or without biopsy, with or without dilation (I.P.)		(I.P.) , Diagnostic, Side Room	Ear, Nose & Throat
2061	Monitered anasthesia benefit for flexible oesophagoscopy (proc code 2060)			Ear, Nose & Throat
2062	Oesophagoscopy, rigid under general anaesthesia, with or with out biopsy, with or with out dilatation (IP)		(I.P.) , Diagnostic, Daycare	Ear, Nose & Throat
2070	Oesophagoscopy with removal of foreign body (I.P.)		(I.P.)	Ear, Nose & Throat
2074	Upper G.I. endoscopy with oesophageal dilatation and laser therapy		Daycare	Ear, Nose & Throat
2077	Oesophageal dilation and insertion of endoprosthesis			Ear, Nose & Throat
2079	Oesophagoscopy with multiple injection of oesophageal varices			Ear, Nose & Throat
2081	Balloon dilatation of the oesophagus (includes endoscopy)		Side Room	Ear, Nose & Throat
2085	Pharyngeal pouch or diverticulum, excision of			Ear, Nose & Throat
2090	Pharyngeal pouch or diverticulum, endoscopic diathermy division			Ear, Nose & Throat
2096	Drainage and marsupialisation of cyst		Daycare	Ear, Nose & Throat
2100	Pharyngolaryngectomy			Ear, Nose & Throat

Code	Description	Payment Rules	Payment Indicators	Speciality
2113	Full pulmonary function studies for the diagnosis and assessment of obstructive and restrictive lung disease. (I.P.)	See note below	Where performed in an approved Aviva Health Laboratory - list available from Aviva on request. I.P., Diagnostic, Side Room	Ear, Nose & Throat
Full pulmonary function studies are not claimable other than in the circumstances described as follows; Includes as a minimum: spirometry and measurement of static lung volumes and diffusing capacity; with or without respiratory flow volume loop, with or without skin testing, with or without pre and post reversability studies, with or without pre and post bronchodilator studies, with or without co2 response curve, with or without airway resistance, with or without body plethysmography(IP) The full pulmonary function studies must be carried out in a computerised pulmunary function laboratory which has the capacity to carry out static lung volumes with helium dilution or plethysmography (I.P.)The full pulmonary function studies must be carried out in a computerised pulmonary function laboratory which has the capacity to carry out static lung volumes with helium dilution or plethysmography and diffusion capacity for carbon monoxide as a minimum and, further, that it has a dedicated lung function technician and operates under the supervision and responsibility of the consultant respiratory physician.				
2115	Incision and drainage, abscess; retropharyngeal or parapharyngeal			Ear, Nose & Throat
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			Ear, Nose & Throat
2117	Polysomnography, limited sleep study together with initiation of nasal CPAP titration for sleep apnoea performed during the same admission (I.P.)	See note below	I.P.	Ear, Nose & Throat
Code 2117 (Polysomnography, limited sleep study together with initiation of nasal CPAP titration for sleep apnoea performed during the same admission) refers to the continuous and simultaneous monitoring and recording of at least 4 parameters of sleep for 4 or more hours with Physician review, interpretation and report. This study should be attended by a Technologist in an Aviva recognised sleep laboratory. Polysomnography must include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (Reimbursement for procedures 2139, 2142, 2117 or 2118 is not claimable in the following circumstances except by special report to and agreement of Aviva's Medical Advisors; patients with COPD whose awake PaO2 is >55 mm Hg and are free of complications; patients with restrictive chest wall, neuromuscular or interstitial lung disease who are not chronically hypoventilating and who are free of polycythemia, pulmonary hypertension, disturbed sleep, morning headaches or daytime somnolence and fatigue; patients that have the risk factors for sleep apnoea of obesity and/or snoring but are free of any symptoms of sleep apnoea; patients with systemic hypertension; patients with nocturnal non-specific cardiac arrhythmias				
2118	Polysomnography, limited sleep study together with two nasal CPAP titration procedures for sleep apnoea performed during the same admission (I.P.)	See note below	I.P.	Ear, Nose & Throat
Code 2118 (Polysomnography, limited sleep study together with two nasal CPAP titration procedures for sleep apnoea performed during the same admission) refers to the continuous and simultaneous monitoring and recording of at least 4 parameters of sleep for 4 or more hours with Physician review, interpretation and report. These studies should be attended by a Technologist in an Aviva recognised sleep laboratory. Polysomnography must include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMReimbursement for either of the procedures 2139, 2142, 2117 or 2118 is not claimable in the following circumstances except by special report to and agreement of Aviva's Medical Advisors; patients with COPD whose awake PaO2 is >55 mm Hg and are free of complications; patients with restrictive chest wall, neuromuscular or interstitial lung disease who are not chronically hypoventilating and who are free of polycythemia, pulmonary hypertension, disturbed sleep, morning headaches or daytime somnolence and fatigue; patients that have the risk factors for sleep apnoea of obesity and/or snoring but are free of any symptoms of sleep apnoea; patients with systemic hypertension; patients with nocturnal non-specific cardiac arrhythmias				

Code	Description	Payment Rules	Payment Indicators	Speciality
2119	Polysomnography, full study with initiation of nasal CPAP titration for sleep apnoea together with a second nasal CPAP titration procedure performed for sleep apnoea during the same admission (I.P.)	See note below	I.P.	Ear, Nose & Throat
Code 2119 (Polysomnography, full study with initiation of nasal CPAP titration for sleep apnoea together with a second nasal CPAP titration procedure performed for sleep apnoea during the same admission) refers to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for 4 or more hours with Physician review, interpretation and report. (b)Polysomnography must include sleep staging (defined below) with 4 or more additional parameters of sleep, attended by a Technologist in an Aviva recognised laboratory. (c)Polysomnography must include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). Additional parameters of sleep include: 1) ECG; 2) airflow; 3) ventilation and respiratory effort; 4) gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis; 5) extremity muscle activity, motor activity-movement; 6) extended EEG monitoring; 7) penile tumescence; 8) gastro-oesophageal reflux and 9) continuous blood pressure monitoring. For a study to be reported as polysomnography, sleep must be recorded and staged. Reimbursement for either of the procedures 2139, 2142, 2117 or 2118 is not claimable in the following circumstances except by special report to and agreement of Aviva's Medical Advisors; patients with COPD whose awake PaO2 is >55 mm Hg and are free of complications; patients with restrictive chest wall, neuromuscular or interstitial lung disease who are not chronically hypoventilating and who are free of polycythemia, pulmonary hypertension, disturbed sleep, morning headaches or daytime somnolence and fatigue; patients that have the risk factors for sleep apnoea of obesity and/or snoring but are free of any symptoms of sleep apnoea; patients with systemic hypertension; patients with nocturnal non-specific cardiac arrhythmiasNOTE: Procedure codes 2143 (Polysomnography, full study with initiation of nasal continuous airway pressure (CPAP) titration for sleep apnoea) and 2144 (Nasal CPAP titration for sleep apnoea), 2119 (Polysomnography, full study with initiation of nasal CPAP titration for sleep apnoea together with a second nasal CPAP titration procedure performed for sleep apnoea during the same admission) and 2122 (Initial nasal CPAP titration for sleep apnoea together with a second nasal CPAP titration procedure performed for sleep apnoea during the same admission) refer to the continuous and simultaneous monitoring and recording of respiration and gas exchange during sleep in conjunction with Nasal CPAP therapy for the purpose of determining the effective pressure required to control obstructive apnoeas previously diagnosed by polysomnography. The study should last 6 hours and be attended by a Technologist with Physician review interpretation and report.				
2121	Polysomnography, full study with Multiple Sleep Latency testing (MSLT) or maintenance of wakefulness, testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness during the same admission (I.P.)	See note below	I.P.	Ear, Nose & Throat
Payable in the following circumstances only: - When excessive daytime sleepiness interferes with the performance of routine daily tasks and clinical features do not suggest a diagnosis of sleep apnoea. - When the Multiple Sleep Latency Test is needed to demonstrate sleep onset REM periods for the diagnosis of narcolepsy. Procedure codes 2148 and 2121 refer to multiple trials during the day to objectively assess sleep tendency by measuring the number of minutes it takes a patient to fall asleep. Parameters necessary for sleep staging (including 1-4 channels of EEG, EOG and EMG) are recorded.				
2122	Initial nasal CPAP titration for sleep apnoea together with a second nasal CPAP titration procedure performed for sleep apnoea during the same admission (I.P.)	See note below	I.P.	Ear, Nose & Throat
Code 2122 (Initial nasal CPAP titration for sleep apnoea together with a second nasal CPAP titration procedure performed for sleep apnoea during the same admission) refers to the continuous and simultaneous monitoring and recording of respiration and gas exchange during sleep in conjunction with Nasal CPAP therapy for the purpose of determining the effective pressure required to control obstructive apnoeas previously diagnosed by polysomnography. The study should last 6 hours and be attended by a Technologist with Physician review interpretation and report.				
2125	Tonsils and/or adenoids (adults), removal of	Max 1 night Hospital Stay		Ear, Nose & Throat
2130	Tonsils and/or adenoids (children under 12 years), removal of	Max 1 night Hospital Stay		Ear, Nose & Throat
2131	Tonsils or tonsils and adenoids, secondary surgical intervention for the arrest of haemorrhage requiring general anaesthetic, following the first operation			Ear, Nose & Throat
2132	Tracheoesophageal puncture and insertion of prosthesis			Ear, Nose & Throat

Code	Description	Payment Rules	Payment Indicators	Speciality
2139	Polysomnography, full study	See note below	Service	Ear, Nose & Throat
Max 1 night Hospital Stay. Code 2139 (Polysomnography, full study) refers to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for 4 or more hours with Physician review, interpretation and report. (b)Polysomnography must include sleep staging (defined below) with 4 or more additional parameters of sleep, attended by a Technologist in an Aviva recognised laboratory. (c) Polysomnography must include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). Additional parameters of sleep include: 1) ECG; 2) airflow; 3) ventilation and respiratory effort; 4) gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis; 5) extremity muscle activity, motor activity-movement; 6) extended EEG monitoring; 7) penile tumescence; 8) gastro-oesophageal reflux and 9) continuous blood pressure monitoring. For a study to be reported as polysomnography, sleep must be recorded and staged. Reimbursement for either of the procedures 2139, 2142, 2117 or 2118 is not claimable in the following circumstances except by special report to and agreement of Aviva's Medical Advisors; patients with COPD whose awake PaO2 is >55 mm Hg and are free of complications; patients with restrictive chest wall, neuromuscular or interstitial lung disease who are not chronically hypoventilating and who are free of polycythemia, pulmonary hypertension, disturbed sleep, morning headaches or daytime somnolence and fatigue; patients that have the risk factors for sleep apnoea of obesity and/or snoring but are free of any symptoms of sleep apnoea; patients with systemic hypertension; patients with nocturnal non-specific cardiac arrhythmias				
2140	Cervix, amputation of (I.P.)		(I.P.)	Gynaecological Operations
2141	Prolonged post exposure evaluation of bronchospasm after excersice, with multiple spirometric determinations as in 2113 including measurement of thoracic gas volumne and expired gas determinations		Side Room, Service	Ear, Nose & Throat
2142	Polysomnography, limited sleep study	See note below	Service	Ear, Nose & Throat
Max 1 night Hospital Stay.Code 2142 (Polysomnography, limited sleep study)refers to the continuous and simultaneous monitoring and recording of at least 4 parameters of sleep for 4 or more hours with Physician review, interpretation and report. These studies should be attended by a Technologist in an Aviva recognised sleep laboratory. Polysomnography must include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMReimbursement for either of the procedures 2139, 2142, 2117 or 2118 is not claimable in the following circumstances except by special report to and agreement of Aviva's Medical Advisors; patients with COPD whose awake PaO2 is >55 mm Hg and are free of complications; patients with restrictive chest wall, neuromuscular or interstitial lung disease who are not chronically hypoventilating and who are free of polycythemia, pulmonary hypertension, disturbed sleep, morning headaches or daytime somnolence and fatigue; patients that have the risk factors for sleep apnoea of obesity and/or snoring but are free of any symptoms of sleep apnoea; patients with systemic hypertension; patients with nocturnal non-specific cardiac arrhythmias				
2143	Polysomnography, full study with initiation of nasal continuous airway pressure (CPAP) titration for sleep apnoea (I.P.)	See note below	I.P., Service	Ear, Nose & Throat
Procedure code 2143 (Polysomnography, full study with initiation of nasal continuous airway pressure (CPAP) titration for sleep apnoea refers to the continuous and simultaneous monitoring and recording of respiration and gas exchange during sleep in conjunction with Nasal CPAP therapy for the purpose of determining the effective pressure required to control obstructive apnoeas previously diagnosed by polysomnography. The study should last 6 hours and be attended by a Technologist with Physician review interpretation and report. (a)Procedure codes 2139 (Polysomnography, full study) and 2143 (Polysomnography, full study with initiation of nasal continuous airway pressure (CPAP) titration for sleep apnoea) and 2119 (Polysomnography, full study with initiation of nasal CPAP titration for sleep apnoea together with a second nasal CPAP titration procedure performed for sleep apnoea during the same admission) refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for 4 or more hours with Physician review, interpretation and report. (b)Polysomnography must include sleep staging (defined below) with 4 or more additional parameters of sleep, attended by a Technologist in an Aviva recognised laboratory. (c)Polysomnography must include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). Additional parameters of sleep include: 1) ECG; 2) airflow; 3) ventilation and respiratory effort; 4) gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis; 5) extremity muscle activity, motor activity-movement; 6) extended EEG monitoring; 7) penile tumescence; 8) gastro-oesophageal reflux and 9) continuous blood pressure monitoring. For a study to be reported as polysomnography, sleep must be recorded and staged. Reimbursement for either of the procedures 2139, 2142, 2117 or 2118 is not claimable in the following circumstances except by special report to and agreement of Aviva's Medical Advisors; patients with COPD whose awake PaO2 is >55 mm Hg and are free of complications; patients with restrictive chest wall, neuromuscular or interstitial lung disease who are not chronically hypoventilating and who are free of polycythemia, pulmonary hypertension, disturbed sleep, morning headaches or daytime somnolence and fatigue; patients that have the risk factors for sleep apnoea of obesity and/or snoring but are free of any symptoms of sleep apnoea; patients with systemic hypertension; patients with nocturnal non-specific cardiac arrhythmias				

Code	Description	Payment Rules	Payment Indicators	Speciality
2144	Nasal CPAP titration for sleep apnoea (I.P.)	See note below	I.P., Service	Ear, Nose & Throat
Code 2144 (Nasal CPAP titration for sleep apnoea), refers to the continuous and simultaneous monitoring and recording of respiration and gas exchange during sleep in conjunction with Nasal CPAP therapy for the purpose of determining the effective pressure required to control obstructive apnoeas previously diagnosed by polysomnography. The study should last 6 hours and be attended by a Technologist with Physician review interpretation and report.				
2145	Cervix, biopsy of (I.P.)		(I.P.) , Diagnostic, Side Room	Gynaecological Operations
2146	Cervix, cone biopsy of (I.P.)		(I.P.) , Diagnostic, Daycare	Gynaecological Operations
2148	Multiple Sleep Latency Testing (MSLT) or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness sleepiness	See note below		Ear, Nose & Throat
Benefit is payable in the following circumstances only: - When excessive daytime sleepiness interferes with the performance of routine daily tasks and clinical features do not suggest a diagnosis of sleep apnoea. - When the Multiple Sleep Latency Test is needed to demonstrate sleep onset REM periods for the diagnosis of narcolepsy. Procedure codes 2148 and 2121 refer to multiple trials during the day to objectively assess sleep tendency by measuring the number of minutes it takes a patient to fall asleep. Parameters necessary for sleep staging (including 1-4 channels of EEG, EOG and EMG) are recorded.				
2150	Cervical polypi, removal of (I.P.)		(I.P.) , Side Room, Service	Gynaecological Operations
2151	Knife cone biopsy of cervix I.P.		(I.P.) , Diagnostic, Daycare	Gynaecological Operations
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.)			Gynaecological Operations - Cervix
2155	Cervix, dilatation of (I.P.)		(I.P.) , Daycare	Gynaecological Operations
2157	Sleep study, simultaneous recording of ventelation, respiratory effort, ECG or heart rate and oxygen saturation, unattended by a technologist (I.P.)		(I.P.)	Ear, Nose & Throat
2160	Cervix, local excision of lesion (I.P.)		(I.P.) , Side Room	Gynaecological Operations
2170	Cervix, suture of (I.P.)		(I.P.)	Gynaecological Operations
2171	Cervical cerclage			Gynaecological Operations
2172	Cerclage of cervix, during pregnancy through abdominal incision			Gynaecological Operations
2175	Cervix, cautery of (I.P.)		(I.P.) , Side Room	Gynaecological Operations
2180	Cervix, examination under anaesthesia (I.P.)		(I.P.) , Diagnostic, Daycare	Gynaecological Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2181	Colposcopy		Diagnostic, Side Room, Service	Gynaecological Operations
2182	Colposcopy with Lletz procedure for lesion removal and/or laser therapy (I.P.)		(I.P.) , Side Room, Service	Gynaecological Operations
2183	Colposcopy and diagnostic biopsy (I.P.)		(I.P.) , Diagnostic, Side Room, Service	Gynaecological Operations
2184	Colposcopy and therapeutic loop electrode biopsy(s) of the cervix (I.P.)		(I.P.) , Side Room, Service	Gynaecological Operations
2185	Caesarean hysterectomy			Gynaecological Operations
2190	Caesarean section (grant in aid for obstetrician's fees)			Gynaecological Operations
2200	Ectopic pregnancy, surgical management (laparoscopic or open): salpingectomy and/or salpingo oophorectomy, unilateral or bilateral			Gynaecological Operations
2206	Vaginal delivery (grant in aid)			Gynaecological Operations
2207	Epidural anaesthesia for vaginal delivery			Gynaecological Operations
2208	General anaesthetic for complications of full-term delivery	See note below		Gynaecological Operations
Benefit is payable when one of the following complications of full term delivery arises: - Retained placenta with or without suturing of perineum - Vulval haematoma at the time of delivery - Primary or secondary post-partum haemorrhage				
2209	Chorionic villus sampling with ultrasound guidance	See note below	Diagnostic, Side Room	Gynaecological Operations
Benefit for procedure codes 2209, 2211, and 2212 is payable for patients at high risk for fetal aneuploidy, fetal anaemia or fetal thrombocytopaenia following one or more prior investigations: (a) abnormal ultrasound findings, b)abnormal pregnancy serum tests, c) patients with Rhesus or Kell sensitisation, d)prior history of fetal abnormalities (e)symptoms or signs suggestive of intrauterine infection. Benefit under procedure codes 2209, 2211, 2212, 2213, 2214, 2216 is payable where the procedure is performed by the consultant obstetrician following referral by the attending consultant				
2211	Amniocentesis, with ultrasound guidance	See note below	Diagnostic, Side Room	Gynaecological Operations
Benefit for procedure codes 2209, 2211, and 2212 is payable for patients at high risk for fetal aneuploidy, fetal anaemia or fetal thrombocytopaenia following one or more prior investigations: (a) abnormal ultrasound findings, b)abnormal pregnancy serum tests, c) patients with Rhesus or Kell sensitisation, d)prior history of fetal abnormalities (e)symptoms or signs suggestive of intrauterine infection. Benefit under procedure codes 2209, 2211, 2212, 2213, 2214, 2216 is payable where the procedure is performed by the consultant obstetrician following referral by the attending consultant				

Code	Description	Payment Rules	Payment Indicators	Speciality
2213	Fetal fluid drainage (e.g. vesicocentesis, thoracentesis, paracentesis), including ultrasound guidance, diagnostic or therapeutic (I.P.)	Benefit for procedure codes 2209, 2211, 2212, 2213, 2214, 2216 is payable where the procedure is performed by the consultant obstetrician following referral by the attending consultant	I.P.	Gynaecological Operations
2214	Transfusion, intrauterine, fetal, with ultrasound guidance, to treat confirmed fetal anemia or thrombocytopenia	Benefit for procedure codes 2209, 2211, 2212, 2213, 2214, 2216 is payable where the procedure is performed by the consultant obstetrician following referral by the attending consultant		Gynaecological Operations
2216	Advanced fetal ultrasound, real time with image documentation, detailed fetal and maternal anatomical examination, only payable following referral by the initial Obstretrician for a documented suspected abnormality identified by a prior ultrasound	Benefit for procedure codes 2209, 2211, 2212, 2213, 2214, 2216 is payable where the procedure is performed by the consultant obstetrician following referral by the attending consultant	Diagnostic, Side Room	Gynaecological Operations
2217	Fetoscopic surgery, using a fetoscope or shunt, and ultrasound guidance, to correct structural malformations	See note below		Gynaecological Operations
Benefit for procedure code 2217 is payable where the procedure is performed by a Consultant with a sub-specialisation in Fetal Medicine 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 extralobular pulmonary sequestration (d) In-utero repair of sacrococcygeal teratoma (e) Fetoscopic laser therapy for treatment of twin-twin transfusion syndrome.				
2218	Advanced foetal ultrasound, real time with image documentation, details foetal and maternal anatomical examination; immediately followed by amniocentesis when an abnormality has been detected (I.P.) see note	Conditions of payment: Benefit under procedure ciodes 2209,2211, 2212, 2213, 2214, 2216 and 2218 is payable where the prodcedure is performed by a Consultant Obstertrician following referal from the attending consultant.	Side Room Only Diagnostic I.P.	Gynaecological Operations - Obstetrical
2225	Dilatation and curettage (diagnostic or therapeutic) (I.P.)		(I.P.) , Daycare	Gynaecological Operations
2235	Microsurgical repair of extensive tubal and peritubal disease consequent on pelvic inflammatory disease and endometriosis including re-implantation of fallopian tube, unilateral			Gynaecological Operations
2240	Microsurgical repair of extensive tubal and peritubal disease consequent on pelvic inflammatory disease and endometriosis including re-implantation of fallopian tubes, bilateral			Gynaecological Operations
2241	Surgical repair of extensive tubal and peritubal disease consequent on pelvic inflammatory disease or endometriosis, unilateral or bilateral			Gynaecological Operations
2244	Hysteroscopy with sampling of endometrium and/or polypectomy, with or without dilatation and curettage , with removal of leiomyomata (I.P.)		(I.P.) , Daycare	Gynaecological Operations
2246	Hysteroscopy with insertion of intrauterine device for menorrhagia (not for contraceptive purposes)		Side Room, Service	Gynaecological Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2247	Insertion of intrauterine device for menorrhagia, not for contraceptive purposes (I.P.)	For procedure code 2247, benefit is only payable following a previous claim for hysteroscopy (code 2248)	I.P. , Side Room, Service	Gynaecological Operations
2248	Hysteroscopy		Side Room	Gynaecological Operations
2249	Hysteroscopy, surgical; with endometrial resection or ablation including microwave (I.P.)		(I.P.) , Daycare	Gynaecological Operations
2250	Total abdominal hysterectomy			Gynaecological Operations
2251	Hysteroscopy and dilatation and curettage (diagnostic or therapeutic) includes polyp removal (I.P.)		(I.P.) , Daycare	Gynaecological Operations
2253	Total vaginal hysterectomy combined with sacrospinous ligament fixation of vagina and both anterior and posterior pelvic floor repair			Gynaecological Operations
2255	Radical abdominal hysterectomy, 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) including robotic approach.			Gynaecological Operations
2256	Total vaginal hysterectomy combined with anterior and posterior pelvic floor repair			Gynaecological Operations
2257	Total abdominal hysterectomy with unilateral or bilateral salpingo oophorectomy			Gynaecological Operations
2258	Resection of ovarian malignancy with total abdominal hysterectomy, complete procedure including robotic approach.			Gynaecological Operations
2259	Debulking of ovarian carcinoma with or without omentectomy, complete procedure			Gynaecological Operations
2260	Sub total abdominal hysterectomy			Gynaecological Operations
2264	Total vaginal hysterectomy with urethropexy or urethroplasty			Gynaecological Operations
2265	Total vaginal hysterectomy			Gynaecological Operations
2267	Total vaginal hysterectomy and anterior or posterior pelvic floor repair			Gynaecological Operations
2268	Vaginal hysterectomy with bilateral salpingo-oophorectomy			Gynaecological Operations
2269	Total vaginal hysterectomy combined with sacrospinous ligament fixation of vagina and anterior or posterior pelvic floor repair			Gynaecological Operations
2273	Marlex sling procedure			Gynaecological Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2280	Myomectomy (multiple) by abdominal incision (I.P.)		(I.P.)	Gynaecological Operations
2280	Myomectomy (multiple) (I.P.) including robotic approach			Gynaecological Operations
2281	Laparoscopy, Surgical, myomectomy (multiple) (I.P.)		I.P.	Gynaecological Operations - Uterus & Adnexa
2285	Myomectomy (single) by abdominal incision (I.P.)		(I.P.)	Gynaecological Operations
2285	Myomectomy (simple, single) (I.P.) including robotic approach			Gynaecological Operations
2286	Laparoscopy, surgical, myomectomy (single) (I.P.)		I.P.	Gynaecological Operations - Uterus & 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.)		I.P.	Gynaecological Operations - Uterus & Adnexa
2289	Oophorectomy, unilateral or bilateral (complete or partial) (I.P.)		(I.P.)	Gynaecological Operations
2300	Ovarian cystectomy unilateral or bilateral (IP)		(I.P.)	Gynaecological Operations
2319	Salpingectomy complete or partial, unilateral or bilateral (I.P.)		(I.P.)	Gynaecological Operations
2354	Salpingostomy or salpingolysis, unilateral or bilateral (I.P.)		(I.P.)	Gynaecological Operations
2364	Microsurgical tuboplasty (salpingostomy or salpingolysis), unilateral or bilateral (I.P.)		(I.P.)	Gynaecological Operations
2365	Salpingo oophorectomy, complete or partial, unilateral or bilateral (I.P.)		(I.P.)	Gynaecological Operations
2370	Uterus, plastic reconstruction of			Gynaecological Operations
2375	Ventrosuspension/Gilliam's operation (I.P.)		(I.P.) , Daycare	Gynaecological Operations
2376	Hysterocontrast sonography (HyCoSy)		Side Room	Gynaecological Operations
2377	Endoscopic periurethral bulking injection (polydimethylsiloxane elastomer) I.P. **Pre-authorisation required**	Benefit is payable for a maxiumum of 3 Treatments	I.P. , Side Room	Gynaecological Operations
2380	Atresia vaginae, relief of (including dilatation of vulva and vagina) (I.P.)		(I.P.) , Daycare	Gynaecological Operations
2385	Bartholin's gland cyst, excision of			Gynaecological Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2390	Bartholin's or Skene's gland, abscess of, incision and drainage (I.P.)		(I.P.)	Gynaecological Operations
2391	Burch colposuspension			Gynaecological Operations
2395	Caruncle, vulvovaginal, removal of (I.P.)		(I.P.) , Daycare	Gynaecological Operations
2400	Colporrhaphy with amputation of cervix, anterior and posterior (Manchester or Fothergill operation)			Gynaecological Operations
2410	Colpotomy		Daycare	Gynaecological Operations
2411	Laparoscopy, surgical, sacrocolpopexy (I.P.)		I.P.	Gynaecological Operations - Vulvovaginal
2415	Cystocele, repair of (I.P.)		(I.P.)	Gynaecological Operations
2420	Cystocele and rectocele, repair of (including colpoperineorraphy)			Gynaecological Operations
2425	Cysts or simple tumours of the vulva or vagina, excision of		Daycare	Gynaecological Operations
2426	Repair of enterocele, vaginal or abdominal approach (I.P.)		(I.P.)	Gynaecological Operations
2430	Hymenotomy (I.P.)		(I.P.) , Daycare	Gynaecological Operations
2435	Hymenectomy		Daycare	Gynaecological Operations
2440	Perineal tear, complete, repair of (IP)		(I.P.)	Gynaecological Operations
2441	Partial vaginectomy (I.P.)		(I.P.)	Gynaecological Operations
2444	Retropubic suspension of neck of bladder.			Gynaecological Operations
2445	Rectocele, repair of (I.P.)		(I.P.)	Gynaecological Operations
2448	Airway resistance		Side Room, Service	Ear, Nose & Throat
2450	Urethropexy for genuine stress incontinence (Stamey, Raz, Burch, Marshall-Marchetti)			Gynaecological Operations
2461	Closure of rectovaginal fistula; vaginal or transanal approach (I.P.)		(I.P.)	Gynaecological Operations
2462	Closure of rectovaginal fistula; abdominal approach with or without colostomy (I.P.)		(I.P.)	Gynaecological Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2465	Vaginal fistulae (vesico vaginal), repair of			Gynaecological Operations
2470	Vaginal wall, suture of			Gynaecological Operations
2471	Sacrospinous ligament fixation for prolapse of vagina (I.P.)		(I.P.)	Gynaecological Operations
2472	Colpopexy, intra- peritoneal approach (uterosacral, levator myorrhaphy)(I.P.)	Where code 2472 or 2474 is carried out at the same time as a hysterectomy, code 2267 will apply.	I.P.	Gynaecological Operations
2473	Colpocleisis (le fort type)			Gynaecological Operations
2474	Colpopexy, vaginal; extra - peritoneal approach (sacrospinous, ilioccygeus)(I.P.)	Where code 2472 or 2474 is carried out at the same time as a hysterectomy, code 2267 will apply.	I.P.	Gynaecological Operations
2480	Vulvectomy, simple, without glands			Gynaecological Operations
2481	Laparoscopy, surgical, with total hysterectomy, with or without removal of tube(s) and/or ovary(s) (I.P.)		I.P.	Gynaecological Operations - Vulvovaginal
2482	Laparoscopy, surgical, radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed (I.P.)		I.P.	Gynaecological Operations - Vulvovaginal
2483	Laparoscopy, surgical, vaginal hysterectomy, with or without removal of tube(s) and/or ovary(s) (I.P.) including robotic approach			Gynaecological Operations
2484	Diagnostic laparoscopy with or without biopsy, with or without tubal irrigation/insufflation (I.P.)		(I.P.) , Daycare	Gynaecological Operations
2485	Vulvectomy, radical, with glands			Gynaecological Operations
2486	Laparoscopy, surgical, total hysterectomy, with or without removal of tube(s) and/or ovary(s) including robotic approach (I.P.)		(I.P.)	Gynaecological Operations
2487	Laparoscopy with or without biopsy and one or more of the following procedures: excision of lesions of ovary; 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.)		(I.P.) , Daycare	Gynaecological Operations
2488	Laparoscopy with or without biopsy. This procedure also includes dilatation and curettage (diagnostic or therapeutic), with or without tubal irrigation/insufflation (I.P.)		(I.P.) , Daycare	Gynaecological Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2489	Laparoscopy with or without biopsy and one or more of the following procedures: excision of lesions of ovary; 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 (I.P.) including robotic approach.			Gynaecological Operations
2490	Conjunctival flap			Ophthalmic Operations
2493	Conjunctivectomy			Ophthalmic Operations
2495	Conjunctival graft			Ophthalmic Operations
2496	Cryotherapy, unilateral		Daycare	Ophthalmic Operations
2497	Cryotherapy, bilateral		Daycare	Ophthalmic Operations
2498	Conjunctival tumour with or without graft		Daycare	Ophthalmic Operations
2500	Cyst/Granuloma, one or more excision of		Side Room	Ophthalmic Operations
2506	Removal of silicone oil not associated with retinal repair at same operative session			Ophthalmic Operations
2510	Pterygium removal		Daycare	Ophthalmic Operations
2511	Pterygium removal and conjunctival graft		Daycare	Ophthalmic Operations
2512	Left eye, intravitreal injection of Lucentis for the treatment of neovascular (wet) age-related macular degeneration (AMD) (Benefit is payable in a hospital setting only) see note	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required	Side Room Only	Ophthalmic Operations - Anterior Segment
2513	Right eye, intravitreal injection of Lucentis for the treatment of neovascular (wet) age-related macular degeneration (AMD) (Benefit is payable in a hospital setting only) see note	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authoisation is required	Side Room Only	Ophthalmic Operations - Anterior Segment
2516	Left eye, intravitreal injection of Lucentis for the treatment of visual impairment due to diabetic macular oedema (DME) (Benefit is payable in a hospital setting only) see note	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authoisation is required	Side Room Only	Ophthalmic Operations - Anterior Segment
2517	Right eye, intravitreal injection of Lucentis for the treatment of visual impairment due to diabetic macular oedema (DME) (Benefit is payable in a hospital setting only) see note	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authoisation is required	Side Room Only	Ophthalmic Operations - Anterior Segment
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) (Benefit is payable in a hospital setting only) see note	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authoisation is required		Ophthalmic Operations - Anterior Segment
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) (Benefit is payable in a hospital setting only) see note	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authoisation is required		Ophthalmic Operations - Anterior Segment
2521	Symblepharon division			Ophthalmic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2522	Removal of foreign body from anterior chamber, magnetic		Daycare	Ophthalmic Operations
2523	Removal of foreign body from anterior chamber, non-magnetic			Ophthalmic Operations
2524	Removal of implanted material from anterior chamber			Ophthalmic Operations
2525	Paracentesis of anterior chamber of eye with or without diagnostic aspiration of aqueous (I.P.)		(I.P.) , Daycare	Ophthalmic Operations
2526	Symblephora, division of (includes conjunctival graft)			Ophthalmic Operations
2527	Conjunctival biopsy			Ophthalmic Operations
2528	Intravitreal injection of a pharmacological agent with or without paracentesis (I.P.)		(I.P.) , Daycare	Ophthalmic Operations
2529	Intravitreal injection of Macugen for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	Payable in a Hospital Setting Only	Payable in a Hospital Setting Only(I.P.) , Daycare	Ophthalmic Operations
2530	Corneal grafting, penetrating/lamellar			Ophthalmic Operations
2531	Removal of sutures (late Stage) post corneal grafting; corneal/ sclera		Side Room	Ophthalmic Operations
2534	Intravitreal injection of Avastin for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	Payable in a Hospital Setting Only.	Sideroom only I.P., Daycare	Ophthalmic Operations
2535	Corneal surface removed and EDTA application			Ophthalmic Operations
2538	Intravitreal injection of Avastin for the treatment of diabetic macular oedema (DMO)(I.P.)	Payable in a Hospital Setting Only.	I.P., Daycare	Ophthalmic Operations
2540	Corneal tattooing			Ophthalmic Operations
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) Benefit is payable in a hospital setting only		Side Room	Ophthalmic Operations
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. Benefit is payable in a hospital setting only		Side Room	Ophthalmic Operations
2546	Corneal scraping		Daycare	Ophthalmic Operations
2547	Corneal biopsy			Ophthalmic Operations
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		Side Room	Ophthalmic Operations
2549	Corneal grafting of pre-cut graft, penetrating/lamellar (not INTACS)			Ophthalmic Operations - Anterior Segment

Code	Description	Payment Rules	Payment Indicators	Speciality
2551	Left eye, intravitreal injection of Avastin for treatment of visual impairment due to diabetic macular oedema (DME)(Benefit is payable in a hospital setting only) see note	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authoisation is required	Side Room Only	Ophthalmic Operations - Anterior Segment
2552	Right eye, intravitreal injection of Avastin for treatment of visual impairment due to diabetic macular oedema (DME)(Benefit is payable in a hospital setting only) see note	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authoisation is required	Side Room Only	Ophthalmic Operations - Anterior Segment
2553	Left eye, intravitreal injection of Avastin for the treatment of neovascular (wet) age-related macular degeneration (AMD) (Benefit is payable in a hospital setting only) see note	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authoisation is required	Side Room Only	Ophthalmic Operations - Anterior Segment
2554	Right eye, intravitreal injection of Avastin for the treatment of neovascular (wet) age-related macular degeneration (AMD) (Benefit is payable in a hospital setting only) see note	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authoisation is required	Side Room Only	Ophthalmic Operations - Anterior Segment
2555	Corneal or scleral tumour, excision			Ophthalmic Operations
2556	Perforating injury cornea and/or sclera not involving uveal tissue			Ophthalmic Operations
2561	Left eye, intravitreal injection of Eylea (Aflibercept) for the treatment of neovascular (wet) age-related macular degeneration (AMD) (Benefit is payable in a hospital setting only)	Benefit is payable for 7 injections per eye in the first 12 month period and 6 in any subsequent 12 month period, in excess of this pre authorisation is required	Side Room	Ophthalmic Operations - Anterior Segment
2562	Right eye, intravitreal injection of Eylea (Aflibercept) for the treatment of neovascular (wet) age-related macular degeneration (AMD) (Benefit is payable in a hospital setting only)	Benefit is payable for 7 injections per eye in the first 12 month period and 6 in any subsequent 12 month period, in excess of this pre authorisation is required	Side Room	Ophthalmic Operations - Anterior Segment
2565	Perforating injury cornea and/or sclera with reposition or resection of uveal tissue			Ophthalmic Operations
2566	Repair of scleral staphyloma with or without graft			Ophthalmic Operations
2575	Foreign body, removal of, from cornea		Side Room, Service	Ophthalmic Operations
2577	Keratotomy, corneal relaxing incision or wedge resection for correction of surgically induced astigmatism that resulted from previous surgury (not for the correction of refractive errrors to correct short sightedness, long sightedness or astigmatism) (I.P.)		(I.P.) , Daycare	Ophthalmic Operations
2579	Excimer laser therapy for the correction of corneal diseases eg. 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 Aviva benefit is not payable		Side Room	Ophthalmic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2580	Paracentesis of anterior chamber of eye for hyphaema with or without irrigation and/or air injection			Ophthalmic Operations
2585	Paracentesis/Saemisch section etc.		Daycare	Ophthalmic Operations
2586	Reform anterior chamber secondary to trabeculectomy or post cataract surgery			Ophthalmic Operations
2591	Botulinum injection for blepharospasm or to induce ptosis		Side Room	Ophthalmic Operations
2592	Repair of ectropion; suture or thermocauterization		Side Room	Ophthalmic Operations
2595	Repair of ectropion; excision of tarsal wedge/extensive (e.g. tarsal strip operations)		Daycare	Ophthalmic Operations
2596	Blepharophimosis, for pathology (not cosmetic)		Daycare	Ophthalmic Operations
2600	Repair of entropion; excision tarsal wedge/extensive (e.g. tarsal strip or capsulopalpebral fascia repairs operation)		Daycare	Ophthalmic Operations
2601	Repair of entropion; suture or thermocauterization		Side Room	Ophthalmic Operations
2605	Epilation, trichiasis, correction of, by other than forceps (e.g. electrosurgery, cryotherapy, laser surgery), unilateral or bilateral, maximum benefit for four months (I.P.)		(I.P.) , Side Room	Ophthalmic Operations
2606	Cryo to lash/electrolysis/ removal lash follicle per course of therapy		Side Room	Ophthalmic Operations
2610	Injury to eyelid, repair (superficial)		Side Room	Ophthalmic Operations
2611	Opening of tarsorrhaphy (I.P.)		(I.P.) , Daycare	Ophthalmic Operations
2615	Injury to eyelid, repair (deep)			Ophthalmic Operations
2621	Excision of chalazion, papilloma, dermoid or other cyst or lesion, single, involving skin, lid margin, tarsus, and/or palpebral conjunctiva (I.P.)		(I.P.) , Side Room, Service	Ophthalmic Operations
2622	Excision of chalazions, papillomas, dermoids or other cysts or lesions, one or both eyelids, involving skin, lid margin, tarsus and/or palpebral conjunctiva (I.P.)		(I.P.) , Side Room, Service	Ophthalmic Operations
2626	Canthotomy (I.P.)		(I.P.) , Side Room	Ophthalmic Operations
2630	Tarsorrhaphy		Daycare	Ophthalmic Operations
2635	Evisceration of eye			Ophthalmic Operations
2640	Excision of eye plus implant			Ophthalmic Operations
2644	Argon or Diode laser or Xenon Arc, for treatment of retinal or choroidal disease, glaucoma, one or more treatments		Side Room	Ophthalmic Operations
2645	Removal of intraocular foreign body			Ophthalmic Operations
2647	YAG laser, for pupil formation, iridectomy, membranectomy, ciliary body treatment, glaucoma, one or more treatments.		Side Room	Ophthalmic Operations
2648	YAG laser capsulotomy, post cataract surgery, one or more treatments		Side Room	Ophthalmic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2660	Removal of eye			Ophthalmic Operations
2665	Prophylaxis of retinal detachment (eg retinal break, lattice degeneration), one or more sessions cryotherapy, diathermy, or photocoagulation/laser	Codes 2665, 2675 and 2676 cannot be combined for benefit payment purposes. Side Room	Side Room	Ophthalmic Operations
2675	Repair of retinal detachment, retinopexy with scleral buckling, scleral resection or scleral implant, etc.	Codes 2665, 2675 and 2676 cannot be combined for benefit payment purposes		Ophthalmic Operations
2676	Vitrectomy - including Prophylaxis of retinal detachment (eg retinal break, lattice degeneration), one or more sessions cryotherapy, diathermy, or photocoagulation/laser	Codes 2665, 2675 and 2676 cannot be combined for benefit payment purposes		Ophthalmic Operations
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 (eg retinal break, lattice degeneration), one or more sessions cryotherapy, diathermy, or photocoagulation/laser			Ophthalmic Operations
2680	Division of anterior synechiae (I.P.)		(I.P.)	Ophthalmic Operations
2685	Cyclodialysis			Ophthalmic Operations
2696	Ciliary body desctuction; Cyclocryotherapy or Diathermy		Daycare	Ophthalmic Operations
2700	Goniotomy			Ophthalmic Operations
2710	Iridectomy			Ophthalmic Operations
2711	Pupil reconstruction post trauma, post surgery			Ophthalmic Operations
2725	Iris tumour, removal			Ophthalmic Operations
2726	Iris biopsy (I.P.)		(I.P.)	Ophthalmic Operations
2740	Trabeculectomy/Drainage procedure	Max 1 Night Hospital Stay		Ophthalmic Operations
2741	Laser trabeculoplasty, one or more treatments		Side Room	Ophthalmic Operations
2742	Trabeculectomy and tubes, etc.			Ophthalmic Operations
2750	Canaliculus repair with or without tube			Ophthalmic Operations
2755	Dacryocystorhinostomy with or without tubes	Max 1 Night Hospital Stay		Ophthalmic Operations
2756	Removal of D.C.R. tube		Side Room	Ophthalmic Operations
2760	Lacrimal abscess, (dacrocystitis) incision		Side Room	Ophthalmic Operations
2761	Lacrimal sac, syringing and probing, unilateral or bilateral		Side Room	Ophthalmic Operations
2764	Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent (I.P.)		(I.P.) , Daycare	Ophthalmic Operations
2766	Punctal closure with cautery or controller		Side Room	Ophthalmic Operations
2768	3 Snip operation of lacrimal punctum		Side Room	Ophthalmic Operations
2769	Correction of everted punctum : cautery only		Side Room	Ophthalmic Operations
2770	Lacrimal sac excision (dacryocystectomy)			Ophthalmic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2771	Lacrimal gland tumour excision			Ophthalmic Operations
2772	Conjunctivo - dacryocystorhinostomy with Lester Jones tube			Ophthalmic Operations
2775	Lacrimal sac, syringing	Code 2756 is only paid as an adjunct to Code 2775, if applicable to the opposing eye	Side Room	Ophthalmic Operations
2779	Repositioning of intraocular lens prosthesis requiring an incision (I.P.)			Ophthalmic Operations
2780	Intraocular lens insertion not associated with concurrent cataract removal secondary implant, for exchange lens associated with previous cataract surgery only (I.P.)	See note below		Ophthalmic Operations
Prosthesis benefit is payable up to the value of monofocal lens only. Benefit is not payable for elective refractive lens replacement surgery, However the Aviva member may elect to have a premium lens inserted at time of surgery and an additional charge for the cost of the lens above an agreed Aviva contribution of €135 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 Aviva				
2785	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (I.P.)		(I.P.)	Ophthalmic Operations
2786	Revision or repair of operative wound of anterior segment of the eye, any type, early or late, major or minor procedure		(I.P.)	Ophthalmic Operations
2795	Lens extraction	See note below		Ophthalmic Operations
Prosthesis benefit is payable up to the value of monofocal lens only. Benefit is not payable for elective refractive lens replacement surgery, However the Aviva member may elect to have a premium lens inserted at time of surgery and an additional charge for the cost of the lens above an agreed Aviva contribution of €135 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 Aviva				
2800	INTACS for members suffering from Keratoconous (I.P.)	In an approved Aviva Health facility. Only for members suffering from Keratoconous and has a clear central cornea	(I.P.) Sideroom	Ophthalmic Operations
2801	Corneal Cross Linking (I.P.)	In an approved Aviva Health facility, having submitted a full report on the members condition	(I.P.) Sideroom	Ophthalmic Operations
2802	Cataract extraction plus insertion of artificial lens (includes phacoemulsification, etc.)	See note below		Ophthalmic Operations
Prosthesis benefit is payable up to the value of monofocal lens only. Benefit is not payable for elective refractive lens replacement surgery, However the Aviva member may elect to have a premium lens inserted at time of surgery and an additional charge for the cost of the lens above an agreed Aviva contribution of €135 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 AvivaBenefit 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 1 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 (d) lens subluxation				
2803	For cataract extraction operations, all forms, where only monitored anaesthesia care is given, the anaesthetic benefit payable is shown opposite			Ophthalmic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2804	Cataract extraction plus insertion of artificial lens (includes phacoemulsification, etc.) Children up to 16 years of age.	See note below		Ophthalmic Operations
Prosthesis benefit is payable up to the value of monofocal lens only. Benefit is not payable for elective refractive lens replacement surgery, However the Aviva member may elect to have a premium lens inserted at time of surgery and an additional charge for the cost of the lens above an agreed Aviva contribution of €135 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 AvivaBenefit 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 1 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 (d) lens subluxation				
2806	Argon laser therapy for pan - retinal photocoagulation of diabetic retinopathy or central retinal vein occlusion (per course of therapy)		Side Room	Ophthalmic Operations
2807	Photodynamic therapy for exudative macular degeneration (one eye) - all inclusive benefit including pre-therapy assessment and counselling, infusion if Visudyne and post-therapy assessment. Also inclusive of outpatient consultations within one week of treatment to provide pre-therapy counselling and post therapy assessment (excluding fluorescein angiography)	Benefit is payable for codes 2807 and 2808 for; (1) The treatment of wet age related degeneration for individuals who have a confirmed diagnosis of (i)Predominantly classic lesions or (ii)pure occult lesions Benefit is not payable for minimally classic or mixed lesions (2) Best corrected visual acuity 6/60 or better	Side Room	Ophthalmic Operations
2808	Photodynamic therapy for exudative macular degeneration (both eyes) - all inclusive benefit including pre-therapy assessment and counselling, infusion if Visudyne and post-therapy assessment. Also inclusive of outpatient consultations within one week of treatment to provide pre-therapy counselling and post therapy assessment (excluding fluorescein angiography)	Benefit is payable for codes 2807 and 2808 for; (1) The treatment of wet age related degeneration for individuals who have a confirmed diagnosis of (i)Predominantly classic lesions or (ii)pure occult lesions Benefit is not payable for minimally classic or mixed lesions (2) Best corrected visual acuity 6/60 or better	Side Room	Ophthalmic Operations
2845	Local resection of ciliary body or choroidal tumour			Ophthalmic Operations
2870	Routine squint operation, horizontal, vertical or oblique	Max 1 Night Hospital Stay		Ophthalmic Operations
2871	Transposition surgery, Jansens, Hummelsheim, Knapp procedure			Ophthalmic Operations
2872	Post operative adjustment(s) of suture(s) (payable once only following strabismus surgery)		Side Room	Ophthalmic Operations
2873	Botulinum toxin injection to extraocular muscles		Side Room, Service	Ophthalmic Operations
2874	Muscle biopsy (I.P.)		(I.P.)	Ophthalmic Operations
2875	Retrobulbar, orbital floor, subconjunctival, subtenons and facial nerve injections (I.P.)		(I.P.) , Side Room	Ophthalmic Operations
2880	Examination of eye under general anaesthetic (I.P.)		(I.P.) , Diagnostic, Daycare	Ophthalmic Operations
2890	Orbit, exenteration of			Ophthalmic Operations
2895	Orbit, exploration of, including biopsy		Daycare	Ophthalmic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
2900	Orbit, removal of foreign body from			Ophthalmic Operations
2905	Orbit, removal of tumour from (Kronlein's operation)			Ophthalmic Operations
2910	Orbit, repair of fracture of			Ophthalmic Operations
2911	Orbitotomy			Ophthalmic Operations
2912	Transnasal wiring			Ophthalmic Operations
2915	Orbit, repair of fracture of, with plastic implant			Ophthalmic Operations
2926	Fluorescein angiography (I.P.)		(I.P.) , Diagnostic, Side Room	Ophthalmic Operations
2927	Tensilon (Edrophonium) test		Side Room	Ophthalmic Operations
2930	Buried tooth roots, (includes more than one root) of one tooth, removal of **Pre-authorisation required**	See note below	Side Room	Dental/Oral/Periodontal Surgery
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.				
2935	Buried tooth roots, (multiple) of teeth, removal of **Pre-authorisation required**	See note below	Daycare	Dental/Oral/Periodontal Surgery
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.				
2940	Dental cysts of maxilla or mandible	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 seperate procedure.	Daycare	Dental/Oral/Periodontal Surgery
2950	Extraction of teeth (more than six permanent teeth) with or without alveolectomy		Daycare	Dental/Oral/Periodontal Surgery
2953	Gingivectomy, one to four teeth **Pre-authorisation required**	See note below	Side Room	Dental/Oral/Periodontal Surgery
Gingivectomy is taken to include the removal of surface deposits from the roots. For codes 2953, 2954, and 2956 benefit is only approved incases of severe gingival hyperplasia and which, in the opinion of Aviva'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 Aviva for this purpose. It is neccesary 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.				

Code	Description	Payment Rules	Payment Indicators	Speciality
2954	Gingivectomy, five to eleven teeth **Pre-authorisation required**	See note below	Side Room	Dental/Oral/Periodontal Surgery
Gingivectomy is taken to include the removal of surface deposits from the roots. For codes 2953, 2954, and 2956 benefit is only approved incases of severe gingival hyperplasia and which, in the opinion of Aviva'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 Aviva for this purpose. It is neccesary 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.				
2956	Gingivectomy, twelve or more teeth **Pre-authorisation required**	See note below		Dental/Oral/Periodontal Surgery
Gingivectomy is taken to include the removal of surface deposits from the roots. For codes 2953, 2954, and 2956 benefit is only approved incases of severe gingival hyperplasia and which, in the opinion of Aviva'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 Aviva for this purpose. It is neccesary 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.				
2973	Removal of one upper impacted or unerupted tooth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
2974	Removal of two upper impacted or unerupted teeth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
2976	Removal of one lower impacted or unerupted tooth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
2977	Removal of two lower impacted or unerupted teeth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
2978	Removal of one impacted or unerupted canine tooth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
2979	Removal of two impacted or unerupted canine teeth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
2980	Labial frenectomy with dissection of tissue **Pre-authorisation required**		Side Room Pre-authorisation required	Dental/Oral/Periodontal Surgery
2981	Removal of four or more impacted or unerupted teeth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
2982	Removal of three impacted or unerupted teeth which includes two lower teeth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
2983	Removal of three impacted or unerupted teeth which includes two upper teeth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
2984	Removal of one upper and one lower impacted or unerupted tooth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
2985	Odontoma, excision of		Daycare	Dental/Oral/Periodontal Surgery
2996	Periodontal mucoperiosteal flap surgery, one to four teeth **Pre-authorisation required**	See note below		Dental/Oral/Periodontal Surgery
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 planing, 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. We have been advised that periodontal surgical procedures have been replaced by more conservative (closed) methods of treatment, such as root planing or scaling. These procedures are not covered by Aviva. However, in exceptional cases, where serious periodontal disease is present which, in the opinion of Aviva's dental advisors, is not treatable by conservative methods and where pocket depths are 6mm or more, Aviva will consider such cases for payment. Prior notification, including full clinical details, relevant radiographs and pocket depths, should be sent to Aviva for this purpose. It is neccesary 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.				
2997	Periodontal mucoperiosteal flap surgery, five to eleven teeth **Pre-authorisation required**	See note below		Dental/Oral/Periodontal Surgery
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 planing, 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. We have been advised that periodontal surgical procedures have been replaced by more conservative (closed) methods of treatment, such as root planing or scaling. These procedures are not covered by Aviva. However, in exceptional cases, where serious periodontal disease is present which, in the opinion of Aviva's dental advisors, is not treatable by conservative methods and where pocket depths are 6mm or more, Aviva will consider such cases for payment. Prior notification, including full clinical details, relevant radiographs and pocket depths, should be sent to Aviva for this purpose. It is neccesary 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.				
2998	Periodontal mucoperiosteal flap surgery, twelve or more teeth **Pre-authorisation required**	See note below		Dental/Oral/Periodontal Surgery
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 planing, 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. We have been advised that periodontal surgical procedures have been replaced by more conservative (closed) methods of treatment, such as root planing or scaling. These procedures are not covered by Aviva. However, in exceptional cases, where serious periodontal disease is present which, in the opinion of Aviva's dental advisors, is not treatable by conservative methods and where pocket depths are 6mm or more, Aviva will consider such cases for payment. Prior notification, including full clinical details, relevant radiographs and pocket depths, should be sent to Aviva for this purpose. It is neccesary 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.				
3001	Surgical exposure and repositioning of an impacted tooth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
3002	Surgical exposure and repositioning of impacted teeth **Pre-authorisation required**		Daycare Pre-authorisation required	Dental/Oral/Periodontal Surgery
3005	Root resection or apicectomy, single, with or without cyst removal and apical curettage		Side Room	Dental/Oral/Periodontal Surgery
3010	Root resection or apicectomy, multiple, with or without cyst removal and apical curettage		Side Room	Dental/Oral/Periodontal Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
3011	Temporomandibular joint, reconstruction osteotomy of ramus and joint with costochondral graft			Dental/Oral/Periodontal Surgery
3012	Temporomandibular joint, open surgical correction of dislocation			Dental/Oral/Periodontal Surgery
3013	Le Fort I osteotomy (includes segmental or cleft) with or without graft			Dental/Oral/Periodontal Surgery
3014	Le Fort II osteotomy (includes via bicoronal flap) with or without graft			Dental/Oral/Periodontal Surgery
3015	Reimplantation of tooth in socket with splinting			Dental/Oral/Periodontal Surgery
3016	Osseointegrated mandibular implant including second stage abutment installation **Pre-authorisation required**	See note below		Dental/Oral Surgery
Osseointegrated mandibular implants; 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 or (b)where a patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exeptional circumstances. In addition, a grant-in-aid of EUR532.29 is payable per implant towards the cost of the implant components.				
3017	Two osseointegrated mandibular implants including second stage abutment installation **Pre-authorisation required**	See note below		Dental/Oral Surgery
Osseointegrated mandibular implants; 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 or (b)where a patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exeptional circumstances. In addition, a grant-in-aid of EUR532.29 is payable per implant towards the cost of the implant components.				
3018	Three osseointegrated mandibular implants including second stage abutment installation **Pre-authorisation required**	See note below		Dental/Oral Surgery
Osseointegrated mandibular implants; 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 or (b)where a patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exeptional circumstances. In addition, a grant-in-aid of EUR532.29 is payable per implant towards the cost of the implant components.				
3019	Four osseointegrated mandibular implants including second stage abutment installation **Pre-authorisation required**	See note below		Dental/Oral Surgery
Osseointegrated mandibular implants; 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 or (b)where a patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exeptional circumstances. In addition, a grant-in-aid of EUR532.29 is payable per implant towards the cost of the implant components.				

Code	Description	Payment Rules	Payment Indicators	Speciality
3020	Simple cysts or epulis, palate or floor of mouth, excision of		Daycare	Dental/Oral Surgery
3021	Five osseointegrated mandibular implants including second stage abutment installation **Pre-authorisation required**	See note below		Dental/Oral Surgery
Osseointegrated mandibular implants; 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 or (b)where a patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exeptional circumstances. In addition, a grant-in-aid of EUR532.29 is payable per implant towards the cost of the implant components.				
3022	Six or more osseointegrated mandibular implants including second stage abutment installation **Pre-authorisation required**	See note below		Dental/Oral Surgery
Osseointegrated mandibular implants; 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 or (b)where a patient has no remaining natural teeth in the mandible opposing a natural dentition in the upper jaw or maxilla, unless there are exeptional circumstances. In addition, a grant-in-aid of EUR532.29 is payable per implant towards the cost of the implant components.				
3024	Le Fort III osteotomy via bicoronal flap with or without graft with Le Fort I			Maxillofacial Surgery
3025	Small tumours of dental origin, removal of, includes biopsy		Side Room	Dental/Oral/Periodontal Surgery
3026	Reconstruction midface, osteotomies (other than Le Fort I type) and bone grafts (includes obtaining autografts) includes via bicoronal flap)			Maxillofacial Surgery
3027	Sagittal split osteotomy with or without graft			Maxillofacial Surgery
3028	Vertical ramus osteotomy, intraoral or extraoral with or without graft			Maxillofacial Surgery
3029	Zygomatic osteotomy, unilateral			Maxillofacial Surgery
3030	Tuberosities, reduction of		Side Room	Ear, Nose & Throat
3031	Osteotomy segmental of maxilla and mandible			Maxillofacial Surgery
3032	Removal of an impacted or unerupted tooth in a patient 16 years or younger under general anaesthetic	Payable to Consultant Maxillofacial Surgeon and Oral Surgeon on the Specialist Register maintained by the Dental Council	Day Care	Dental / Oral Surgery
3033	Removal of two impacted or unerupted tooth in a patient 16 years or younger under general anaesthetic	Payable to Consultant Maxillofacial Surgeon and Oral Surgeon on the Specialist Register maintained by the Dental Council	Day Care	Dental / Oral Surgery
3034	Surgical removal of odontoma(s) in a patient 16 years or younger under general anaesthetic	Payable to Consultant Maxillofacial Surgeon and Oral Surgeon on the Specialist Register maintained by the Dental Council	Day Care	Dental / Oral Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
3035	Abscess or infected tendon sheath of palmar spaces, drainage of			Orthopaedic Operations
3036	Open surgical exposure of a single impacted tooth in compact bone in patients 16 years or younger	Payable to Consultant Maxillofacial Surgeon and Oral Surgeon on the Specialist Register maintained by the Dental Council	Day Care	Dental / Oral Surgery
3037	Open surgical exposure of two teeth in compact bone in patients 16 years or younger	Payable to Consultant Maxillofacial Surgeon and Oral Surgeon on the Specialist Register maintained by the Dental Council	Day Care	Dental / Oral Surgery
3039	Synovectomy of metacarpophalangeal joints, (more than two joints) with release of ulnar intrinsic tendons			Orthopaedic Operations
3040	Arthrodesis of joint (I.P.)		(I.P.)	Orthopaedic Operations
3041	Arthrodesis of the carpometacarpal joint of the thumb using bone graft			Orthopaedic Operations
3045	Arthroplasty, using joint prosthesis, single (IP)		(I.P.)	Orthopaedic Operations
3050	Arthroplasty, using joint prosthesis, two joints (IP)		(I.P.)	Orthopaedic Operations
3055	Arthroplasty, using joint prosthesis, more than two joints(IP)		(I.P.)	Orthopaedic Operations
3060	Bone tumours (benign), excision of			Orthopaedic Operations
3061	Giant Cell Tumour, excision of primary or recurrent lesion from bone or soft tissue		Independent Procedure	Plastic Surgery
3070	Bursectomy			Orthopaedic Operations
3075	Chondroma, multiple, with bone graft, excision of			Orthopaedic Operations
3080	Chondroma, single, with bone graft, excision of			Orthopaedic Operations
3085	Exostosis, excision of		Daycare	Orthopaedic Operations
3095	Fracture of phalanges and/or metacarpals, closed reduction (I.P.)		(I.P.) , Daycare	Orthopaedic Operations
3100	Fracture of phalanx, single, internal fixation			Orthopaedic Operations
3105	Fracture of phalanges, multiple, internal fixation			Orthopaedic Operations
3106	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation when performed, for complex crush injuries requiring bone reconstruction			Orthopaedic Operations
3110	Ganglion of hand, surgical removal of		Side Room	Orthopaedic Operations
3115	Manipulation for treatment of dislocation of metacarpophalangeal joint (I.P.)		(I.P.) , Daycare, Service	Orthopaedic Operations
3125	Nails, removal of all			Orthopaedic Operations
3126	Debridement and repair of nail bed, for simple crush injuries		Side Room	Orthopaedic Operations
3131	Application of Plaster of Paris casts as a separate procedure not associated with concurrent surgery (I.P.)		(I.P.) , General Anaesthesia, Day Care	Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
3135	Synovioma, excision of		Daycare	Orthopaedic Operations
3136	Tendon repair, flexor-double (hand)			Orthopaedic Operations
3140	Traumatic amputation of finger, single, reconstructive operation			Orthopaedic Operations
3145	Amputation of two or more fingers			Orthopaedic Operations
3150	Trigger finger, correction of		Daycare	Orthopaedic Operations
3159	Arthroscopy of the wrist		Diagnostic, Daycare	Orthopaedic Operations
3160	Arthrodesis, using bone graft			Orthopaedic Operations
3161	Arthroscopy, wrist, surgical; for infection, lavage and drainage		Day Care Diagnostic	Orthopaedic Operations - Wrist
3162	Arthroscopy, wrist, surgical; synovectomy, partial (I.P.)		I.P.	Orthopaedic Operations - Wrist
3163	Arthroscopy, wrist, surgical; synovectomy, complete (I.P.)		I.P.	Orthopaedic Operations - Wrist
3164	Arthroscopy, wrist, surgical; excision and /or repair of triangular fibrocartilage and/or joint debridement (I.P.)		I.P.	Orthopaedic Operations - Wrist
3165	Arthroplasty (I.P.)		(I.P.)	Orthopaedic Operations
3166	Arthroscopy, wrist, surgical; internal fixation for fracture or instability (I.P.)		I.P.	Orthopaedic Operations - Wrist
3175	Bone grafting operation on scaphoid			Orthopaedic Operations
3176	Herbert screw fixation, scaphoid			Orthopaedic Operations
3180	Carpal bone (lunate scaphoid trapezium), excision of			Orthopaedic Operations
3181	Trapezial joint replacement			Orthopaedic Operations
3184	Injection , therapeutic (e.g. Local anesthetic costicosteroid for the relief of symptoms of carpal tunnel syndrome) under ultrasound guidance (I.P.)		(I.P.) , Side Room, Service	Orthopaedic Operations
3185	Carpal tunnel, decompression		Daycare	Orthopaedic Operations
3190	Carpus or peri-carpal dislocations, manipulation			Orthopaedic Operations
3191	Endoscopy, wrist, surgical, with release of transverse carpal ligament		Daycare	Orthopaedic Operations
3192	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint			Orthopaedic Operations
3195	Corrective osteotomy of lower end of radius			Orthopaedic Operations
3200	Dislocation of wrist, open reduction of			Orthopaedic Operations
3205	Fracture (Colles'), internal fixation of			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
3210	Fracture (Colles'), manipulation and Plaster of Paris		Side Room	Orthopaedic Operations
3211	Fracture of distal radius, external fixation of			Orthopaedic Operations
3225	Ganglion, surgical removal of		Daycare	Orthopaedic Operations
3229	Intercarpal fusion			Orthopaedic Operations
3230	Nerve block for pain control, wrist joint		Side Room, Service	Orthopaedic Operations
3235	Nerve, median and ulnar nerve, repair of			Orthopaedic Operations
3240	Nerve, median or ulnar nerve, repair of			Orthopaedic Operations
3245	Radial styloid, excision of			Orthopaedic Operations
3250	Sympathetic block		Side Room	Orthopaedic Operations
3255	Synovectomy of wrist joint			Orthopaedic Operations
3260	Tendon, repair at wrist, single			Orthopaedic Operations
3265	Tendons, repair at wrist, multiple			Orthopaedic Operations
3270	Tendon transfer about the wrist, single			Orthopaedic Operations
3271	Tendon transfer about the wrist, multiple			Orthopaedic Operations
3275	Ulna, lower end of (malunited Colles'), excision of			Orthopaedic Operations
3276	Smith's or Barton's fractures, internal fixation of			Orthopaedic Operations
3277	Manipulation of wrist under general anaesthetic (to gain loss of motion following a surgical procedure or due to scar tissue)		Daycare	Orthopaedic Operations
3280	Amputation through forearm			Orthopaedic Operations
3285	Annular ligament, repair of			Orthopaedic Operations
3290	Anterior capsulotomy and excision (myositis ossificans)			Orthopaedic Operations
3295	Arthrodesis			Orthopaedic Operations
3296	Arthroscopy, elbow, diagnostic, with or without synovial biopsy, removal of loose body or foreign body, synovectomy, debridement		Daycare	Orthopaedic Operations
3297	Arthroscopy, elbow, surgical; includes extensive debridement to all parts of the elbow joint, with complete synovectomy (osteocapsular arthroplasty)(I.P.)		I.P.	Orthopaedic Operations
3300	Arthroplasty (Forearm & Elbow) (I.P.)		(I.P.)	Orthopaedic Operations
3315	Drainage of elbow joint			Orthopaedic Operations
3316	External fixation, upper limb			Orthopaedic Operations
3320	Fracture forearm (complete), closed reduction and Plaster of Paris			Orthopaedic Operations
3325	Fracture forearm (greenstick), closed reduction and Plaster of Paris			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
3330	Fracture about elbow, closed manipulation of			Orthopaedic Operations
3335	Fracture dislocation, open reduction of (forearm/elbow)			Orthopaedic Operations
3340	Fracture of forearm bones, open reduction of			Orthopaedic Operations
3341	Open reduction, internal fixation and bone grafting (forearm/elbow)			Orthopaedic Operations
3345	Fracture of lateral condyle, open reduction of			Orthopaedic Operations
3350	Fracture of medial condyle, open reduction of			Orthopaedic Operations
3355	Fracture (supracondylar), closed reduction of			Orthopaedic Operations
3360	Fracture, olecranon, screwing of			Orthopaedic Operations
3365	Closed treatment of elbow dislocation (I.P.)		(I.P.) , Service	Orthopaedic Operations
3370	Nerve, ulnar, transplant			Orthopaedic Operations
3375	Olecranon bursa, removal of		Daycare	Orthopaedic Operations
3380	Radius, excision of head of			Orthopaedic Operations
3381	Silastic interposition of radial head			Orthopaedic Operations
3385	Open synovectomy of elbow joint			Orthopaedic Operations
3390	Tendon transplants about the elbow			Orthopaedic Operations
3395	Tendon sheaths, removal of, in forearm		Daycare	Orthopaedic Operations
3400	Tennis elbow, advancement of extensor muscles			Orthopaedic Operations
3401	Arthroscopy, shoulder, surgical, with removal of loose body or foreign body, synovectomy, debridement			Orthopaedic Operations
3402	Arthroscopic suture capsulorrhaphy for anterior shoulder instability			Orthopaedic Operations
3403	Arthroscopy, shoulder, diagnostic with or without synovial biopsy (I.P.)		Diagnostic, I.P.	Orthopaedic Operations
3404	Open acromioplasty of shoulder including excision of acromio-clavicular joint			Orthopaedic Operations
3405	Open acromio-clavicular joint, excision of			Orthopaedic Operations
3406	Decompression fasciotomy, forearm and/or wrist flexor or extensor compartment; with or without debridement of non-viable muscle and/or nerve			Orthopaedic Operations
3407	Arthroscopy, shoulder, surgical; repair of SLAP lesion (I.P.)		Independent Procedure	Orthopaedic Operations
3408	Arthroscopy, shoulder, surgical; with rotor cuff repair (I.P.)		I.P.	Orthopaedic Operations
3409	Shoulder replacement, total shoulder (includes reverse total shoulder Arthroplasty) (I.P.)		I.P.	Orthopaedic Operations
3410	Acromio-clavicular joint, open reduction of			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
3411	Arthroscopic subacromial decompression, includes diagnostic arthroscopy (code 3403) (I.P.)		I.P.	Orthopaedic Operations
3412	Arthroscopic excision outer end of clavicle			Orthopaedic Operations
3413	Arthroscopic excision outer end of clavicle/subacromial decompression, includes diagnostic arthroscopy (Code 3403)			Orthopaedic Operations
3414	Arthroscopy, Shoulder, Surgical; biceps tenodesis (I.P.)		I.P.	Orthopaedic Operations - Humerus & Shoulder
3415	Amputation through arm			Orthopaedic Operations
3420	Arthrodesis, humerus/shoulder			Orthopaedic Operations
3430	Biopsy, synovial, humerus/shoulder		Diagnostic	Orthopaedic Operations
3435	Capsulotomy (acute capsulitis)			Orthopaedic Operations
3440	Disarticulation, humerus/shoulder			Orthopaedic Operations
3445	Dislocation, open reduction of, humerus/shoulder			Orthopaedic Operations
3450	Dislocation, acute, manipulation under general anaesthetic, humerus/shoulder		Daycare	Orthopaedic Operations
3455	Dislocation, Open recurrent, operation for, humerus/shoulder			Orthopaedic Operations
3464	Forequarter amputation			Orthopaedic Operations
3465	Fractured clavicle, closed reduction of			Orthopaedic Operations
3470	Fractured clavicle, open reduction of			Orthopaedic Operations
3471	Open reduction internal fixation and bone grafting non union of a fracture of the clavicle			Orthopaedic Operations
3475	Fractured humerus, open reduction with internal fixation			Orthopaedic Operations
3480	Fractured humerus, open reduction and bone graft			Orthopaedic Operations
3485	Fractured humerus, closed reduction of			Orthopaedic Operations
3495	Manipulation of shoulder joint under general anaesthetic (I.P.)		(I.P.) , Daycare, Service	Orthopaedic Operations
3500	Repair of capsule (in rotator cuff injuries) humerus/shoulder, includes diagnostic arthroscopy +/- Arthroscopic subacromial descromprssion			Orthopaedic Operations
3503	Subacromial bursectomy (endoscopic or open) including Arthroscopy, shoulder, diagnostic with or without synovial biopsy (I.P.)		Independent Procedure, Diagnostic	Orthopaedic Operations
3509	Saucerising humerus in chronic osteomyelitis			Orthopaedic Operations
3510	Subacromial bursectomy			Orthopaedic Operations
3515	Tendon transplant about shoulder			Orthopaedic Operations
3520	Anterior drainage of paravertebral abscess with bone graft			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
3521	Anterior release and fusion for scoliosis/kyphosis			Orthopaedic Operations
3525	Antero lateral decompression			Orthopaedic Operations
3526	Antero lateral decompression involving two or more levels			Orthopaedic Operations
3530	Coccyx, excision of			Orthopaedic Operations
3540	Epidural injection (I.P.)		(I.P.) , Daycare, Service	Orthopaedic Operations
3542	Epidural injection, of anaesthetic substances and/or therapeutic substances, diagnostic or therapeutic under radiological guidance one or more levels at the same session (I.P.)		(I.P.) , Daycare, Service	Orthopaedic Operations
3545	Epidural infusion with cannula		Daycare, Service	Orthopaedic Operations
3550	Fracture or fracture dislocation of spine traction, reduction and plaster cast application			Orthopaedic Operations
3555	Fractured spine, open reduction of, including spinal canal clearance of bony and disc material in a spinal trauma setting			Neurosurgical Operations
3560	Intervertebral disc, removal of			Orthopaedic Operations
3561	Needle aspiration of intervertebral disc		Side Room	Orthopaedic Operations
3563	Excision of thoracic intervertebral disc			Orthopaedic Operations
3565	Laminectomy and exploration with or without rhizotomy			Orthopaedic Operations
3566	Neuralarch biopsy			Orthopaedic Operations
3571	Posterior spinal fusion with instrumentation for scoliosis (up to 8 levels)	Note Code 3571 and 35711 cannot be charged together in any one specific case		Neurosurgical Operations
35711	Posterior spinal fusion with instrumentation for scoliosis (over 8 levels)	Note Code 3571 and 35711 cannot be charged together in any one specific case		Neurosurgical Operations
3580	Spina bifida, closure of			Orthopaedic Operations
3585	Spina bifida, lumbar spinal osteotomy (may include spinal chevron osteotomy up to 5 levels)	Note Code 3585, 35851 and 35852 cannot be charged together in any one specific case		Neurosurgical Operations
35851	Spina bifida, lumbar spinal osteotomy (may include spinal chevron osteotomy more than 5 levels)	Note Code 3585, 35851, 35852 and 35853 cannot be charged together in any one specific case		Neurosurgical Operations
35852	Pedicle subtraction osteotomy (all levels)	Note Code 3585, 35851, 35852 and 35853 cannot be charged together in any one specific case		Neurosurgical Operations
35853	Vertebral Column resection	Note Code 3585, 35851, 35852 and 35853 cannot be charged together in any one specific case		Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
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)			Neurosurgical Operations
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	Note Code 3587, 35871 and 35872 cannot be charged together in any one specific case		Neurosurgical Operations
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	Note Code 3587, 35871 and 35872 cannot be charged together in any one specific case		Neurosurgical Operations
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	Note Code 3587, 35871 and 35872 cannot be charged together in any one specific case		Neurosurgical Operations
3588	Spinal fusion, simultaneous combined anterior and posterior fusion, one level, without instrumentation			Orthopaedic Operations
3589	Spinal fusion, simultaneous combined anterior and posterior fusion, multiple level, without instrumentation			Orthopaedic Operations
3590	Spinal manipulation, under general anaesthetic		Daycare	Orthopaedic Operations
3591	Closed reduction of cervical spinal fracture (s) / dislocation (I.P.)		I.P.	Neurosurgical Operations
3592	External fixature of the spine			Orthopaedic Operations
3595	Spinal fusion			Orthopaedic Operations
3596	Spinal fusion, in scoliosis spine, anterior and posterior			Orthopaedic Operations
3597	Spinal fusion involving two or more levels			Orthopaedic Operations
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	Note Code 3598, 35981 and 35982 cannot be charged together in any one specific case		Neurosurgical Operations
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	Note Code 3598, 35981 and 35982 cannot be charged together in any one specific case		Neurosurgical Operations
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	Note Code 3598, 35981 and 35982 cannot be charged together in any one specific case		Neurosurgical Operations
3599	Cervical spine laminoplasty with segmental plate fixation (I.P.)		I.P.	Neurosurgical Operations
3600	Vertebral body biopsy		Diagnostic	Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
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)			Neurosurgical Operations
3602	Removal of spinal instrumentation			Orthopaedic Operations
3603	Spinal stenosis decompression, one level			Orthopaedic Operations
3604	Spinal stenosis decompression, two levels			Orthopaedic Operations
3605	Arthrodesis, sacro iliac joint (IP)		(I.P.)	Orthopaedic Operations
3606	Percutaneous vertebroplasty, single thoracic vertebra (may include Balloon kyphoplasty)			Neurosurgical Operations
3607	Percutaneous vertebroplasty, single lumbar vertebra (may include Balloon kyphoplasty			Neurosurgical Operations
3608	Dynamic lumbar stabilisation with interspinous implant (I.P.)		(I.P.)	Orthopaedic Operations
3609	Percutaneous vertebral augmentation, including cavity creation, using mechanical device, e.g. kyphoplasty, one level (unilateral or bilateral), lumbar			Orthopaedic Operations
3610	Aspiration, sacro iliac joint		Side Room, Service	Orthopaedic Operations
3611	Percutaneous vertebral augmentation, including cavity creation, using mechanical device, e.g. kyphoplasty, one level (unilateral or bilateral), thoracic			Orthopaedic Operations
3612	Posterior foramen magnum (I.P.)		I.P.	Neurosurgical Operations
3615	Biopsy of sacro iliac joint region		Diagnostic	Orthopaedic Operations
3620	Injection of sacro iliac joint region (I.P.)		(I.P.) , Side Room, Service	Orthopaedic Operations
3625	Pelvic osteotomy bilateral in ectopia vesica			Orthopaedic Operations
3630	Acetabuloplasty, shelf operation			Orthopaedic Operations
3631	Internal fixation of acetabular fractures			Orthopaedic Operations
3635	Acute dislocation, manipulation for			Orthopaedic Operations
3636	Congenital dislocation of hip, E.U.A. and P.O.P. (I.P.)		(I.P.) , Daycare	Orthopaedic Operations
3640	Acute dislocation or fracture dislocation, open reduction, hip/ femur			Orthopaedic Operations
3645	Above knee amputation			Orthopaedic Operations
3650	Arthrodesis, hip/femur			Orthopaedic Operations
3653	Arthroscopy, hip, surgical; with acetabuloplasty (i.e. treatment of pincer lesion) without labral repair			Orthopaedic Operations
3654	Arthroscopy, hip, surgical; with acetabuloplasty (i.e. treatment of pincer lesion) includes labral repair			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
3655	Arthroplasty of hip using prosthesis, bilateral (IP)		(I.P.)	Orthopaedic Operations
3656	Arthroscopy, hip, diagnostic; with or without synovial biopsy (separate procedure) (I.P.)		(I.P.)	Orthopaedic Operations
3657	Arthroscopy, hip, surgical; with synovectomy (I.P.)		(I.P.)	Orthopaedic Operations
3658	Arthroscopy, hip, surgical; with removal of loose body or foreign body with femoroplasty (i.e. treatment of CAM lesion)			Orthopaedic Operations
3659	Arthroscopy, hip, surgical with debridement/shaving of articular cartilage (chondroplasty), abrasion arthrosplasty and/or resection of labrum			Orthopaedic Operations
3660	Arthroplasty of hip using prosthesis, unilateral (IP)		(I.P.)	Orthopaedic Operations
3661	Revision of total hip arthroplasty, acetabular and femoral components with or without autograft or allograft (IP)		(I.P.)	Orthopaedic Operations
3665	Arthrotomy for loose body	485.00		Orthopaedic Operations
3666	Metal on metal hip resurfacing arthoplasty (unilateral) (IP)		(I.P.)	Orthopaedic Operations
3667	Metal on metal hip resurfacing arthoplasty (bilateral)(IP)		(I.P.)	Orthopaedic Operations
3675	Corrective osteotomy with or without internal fixation			Orthopaedic Operations
3680	Curetting of greater trochanter and bursectomy			Orthopaedic Operations
3690	Hind quarter amputation			Orthopaedic Operations
3695	Drainage of hip joint for acute infection (I.P.)		(I.P.)	Orthopaedic Operations
3700	Exostosis of femoral neck in slipped femoral epiphysis, excision of			Orthopaedic Operations
3705	Femoral condyle, osteotomy of (I.P.)		(I.P.)	Orthopaedic Operations
3709	Fractured femur, hemiarthroplasty			Orthopaedic Operations
3710	Fractured shaft of femur, open reduction, with internal fixation			Orthopaedic Operations
3715	Fractured shaft of femur, closed reduction, with traction			Orthopaedic Operations
3720	Fractured femur (supracondylar) open reduction of			Orthopaedic Operations
3723	Fractured shaft of femur, closed intramedullary nailing			Orthopaedic Operations
3724	Fractured shaft of femur closed intramedullary, interlocking nail			Orthopaedic Operations
3725	Fracture of neck of femur, intramedullary nail fixation of			Orthopaedic Operations
3729	Repair , non union or malunion, femur, distal to head and neck with iliac or other autogenous bone graft (includes obtaining graft)			Orthopaedic Operations
3730	Fracture of femur (pertrochanteric or introchanteric) intramedullary nail fixation of			Orthopaedic Operations
3731	Open treatment of anterior ring fracture and/or dislocation with internal fixation, (includes pubic symphysis and/or rami)			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
3732	Open treatment of posterior ring fracture and/or dislocation with internal fixation, (includes ilium, sacro-iliac joint and/or sacrum)			Orthopaedic Operations
3733	Pelvic fracture, external fixation			Orthopaedic Operations
3735	Hip deformity, soft tissue operations for correction of (I.P.)		(I.P.)	Orthopaedic Operations
3745	Manipulation of hip, closed, requiring general anaesthetic		Service	Orthopaedic Operations
3750	Open reduction and/or rotation osteotomy			Orthopaedic Operations
3751	Open reduction, pelvic osteotomy and femoral shortening			Orthopaedic Operations
3755	Pelvic osteotomy			Orthopaedic Operations
3756	Modified innominate osteotomy including bone graft			Orthopaedic Operations
3760	Pseudoarthroplasty of hip (Girdlestone operation)			Orthopaedic Operations
3765	Slipped femoral epiphysis, intramedullary nail, fixation of			Orthopaedic Operations
3770	Slipped femoral epiphysis, lower end, stapling of			Orthopaedic Operations
3775	Synovectomy of hip joint and debridement			Orthopaedic Operations
3785	Transplantation of psoas muscle to greater trochanter (Mustard's or Sherrard's operation)			Orthopaedic Operations
3790	Below knee amputation			Orthopaedic Operations
3795	Arthrodesis, knee			Orthopaedic Operations
3815	Baker's cyst, excision of			Orthopaedic Operations
3816	Bone transportation			Orthopaedic Operations
3817	Removal of fixator device, tibia		Daycare	Orthopaedic Operations
3818	Arthroscopy of knee, surgical; with lateral release		Daycare	Orthopaedic Operations
3819	Arthroscopy, knee, diagnostic, with or without synovial biopsy		Diagnostic, Daycare	Orthopaedic Operations
3820	Cartilage(s), removal of, knee		Daycare	Orthopaedic Operations
3821	Arthroscopy and removal of cartilage, knee	Cannot be charged in conjunction with Code 3839	Daycare	Orthopaedic Operations
3822	Arthroscopy of the knee for removal of loose body or foreign body, synovectomy, debridement (I.P.)		(I.P.) , Daycare	Orthopaedic Operations
3825	Corrective osteotomy of tibia in region of knee			Orthopaedic Operations
3830	Corrective osteotomy of tibia in region of ankle			Orthopaedic Operations
3833	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion) medical or lateral) (I.P.)		I.P.	Orthopaedic Operations - Knee & Lower Leg
3834	Arthroscopy, knee, surgical; for infection, lavage and drainage (I.P.)		I.P.	Orthopaedic Operations - Knee & Lower Leg
3835	Cruciate ligaments, repair			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
3836	Arthroscopic anterior cruciate ligament reconstruction			Orthopaedic Operations
3837	Arthroscopic anterior cruciate ligament reconstruction and menisectomy			Orthopaedic Operations
3838	Arthroscopic anterior cruciate ligament reconstruction and menisceal repair			Orthopaedic Operations
3839	Arthroscopic menisceal repair	Cannot be charged in conjunction with Code 3821	Daycare	Orthopaedic Operations
3840	Drainage of joint in acute infection			Orthopaedic Operations
3845	Exploration of joint, knee/lower leg			Orthopaedic Operations
3850	Fixed flexion of knee, soft tissue operations for			Orthopaedic Operations
3855	Fracture dislocation of knee joint, operations for			Orthopaedic Operations
3860	Fracture of tibia (condylar) open reduction of			Orthopaedic Operations
3865	Fracture of tibial shaft, open reduction and internal fixation			Orthopaedic Operations
3870	Fracture of tibial shaft, closed reduction of			Orthopaedic Operations
3871	Fracture of tibial shaft, closed intra-medullary, interlocking nail			Orthopaedic Operations
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.)		I.P.	Orthopaedic Operations - Knee & 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.)		I.P.	Orthopaedic Operations - Knee & Lower Leg
3874	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation when performed (includes arthroscopy) (I.P.)		I.P.	Orthopaedic Operations - Knee & Lower Leg
3876	Arthroscopically aided treatment fotibial fracture, proximal (plateau); bicondylar, includes internal fixation, when performed (includes arthroscopy) (I.P.)		I.P.	Orthopaedic Operations - Knee & Lower Leg
3880	Lateral ligaments, repair			Orthopaedic Operations
3885	Manipulation under general anaesthetic, knee/lower leg (I.P.)		(I.P.) , Service	Orthopaedic Operations
3890	Osteochondritis dissecans, Smillies operation for			Orthopaedic Operations
3895	Patellectomy or open reduction of fractured patella			Orthopaedic Operations
3896	Resurfacing of patella			Orthopaedic Operations
3900	Pre patellar bursa, removal of		Daycare	Orthopaedic Operations
3905	Plication of vastii, etc.			Orthopaedic Operations
3909	Prosthetic replacement (total) of knee joints, bilateral (IP)		(I.P.)	Orthopaedic Operations
3910	Prosthetic replacement (total) of knee joint, unilateral (IP)		(I.P.)	Orthopaedic Operations
3911	Revision of arthroplasty of knee joint, with or without allograft, one or more components (IP)		(I.P.)	Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
3912	Reconstruction of knee, (anterior cruciate)			Orthopaedic Operations
3914	Patellofemoral arthroplasty of knee joint,; condyle and plateau medial or lateral compartment (I.P.)		I.P.	Orthopaedic Operations - Knee & Lower Leg
3915	Quadriceps mechanism, repair			Orthopaedic Operations
3920	Slipped epiphysis, stapling of, or epiphysiodesis			Orthopaedic Operations
3925	Slipped epiphysis (tibial and femoral combined), stapling of, or epiphysiodesis			Orthopaedic Operations
3930	Slipped epiphyses (bilateral tibial), stapling of			Orthopaedic Operations
3931	Slocum's or similar procedure			Orthopaedic Operations
3935	Synovectomy			Orthopaedic Operations
3940	Synovial biopsy, knee/lower leg		Diagnostic, Daycare	Orthopaedic Operations
3944	Reconstruction (advancement) posterior tibial tendon with excision of accessory tarsal navicular bone (eg Kidner type procedure)			Orthopaedic Operations
3945	Tendon transplants about knee joint			Orthopaedic Operations
3950	Transplant of tibial tubercle			Orthopaedic Operations
3951	Decompression fasciotomy, leg			Orthopaedic Operations
3955	Arthrodesis of ankle joint			Orthopaedic Operations
3956	Arthroscopy, ankle, with or without removal of loose body or foreign body, with or without synovectomy, debridement		Daycare	Orthopaedic Operations
3957	Arthroplasty (ankle) (IP)		(I.P.)	Orthopaedic Operations
3958	Arthroplasty, ankle with implant (total ankle)(IP)		(I.P.)	Orthopaedic Operations
3959	Arthroplasty, ankle revision, total ankle (IP)		(I.P.)	Orthopaedic Operations
3961	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect (I.P.)		I.P.	Orthopaedic Operations - 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.)		I.P.	Orthopaedic Operations - Ankle
3963	Arthroscopy, subtalar joint, surgical, with subtalar arthrodesis (I.P.)		I.P.	Orthopaedic Operations - Ankle
3965	Fracture of medial or lateral malleolus (1st degree Pott's fracture), internal fixation of			Orthopaedic Operations
3970	Fracture of posterior malleolus without fracture of other malleolus, internal fixation of			Orthopaedic Operations
3971	Open treatment of bimalleolar ankle fracture, with or without internal fixation			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
3972	Fracture of trimalleolar ankle fracture with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip			Orthopaedic Operations
3975	Fracture, Pott's, closed reduction of			Orthopaedic Operations
3976	Closed reduction manipulation of dislocated ankle joint, with or without percutaneous sketetal fixataion such as pins			Orthopaedic Operations
3980	Synovectomy and debridement			Orthopaedic Operations
3985	Synovial biopsy, ankle		Diagnostic, Daycare	Orthopaedic Operations
3986	Talar fracture, open reduction and internal fixation of			Orthopaedic Operations
3990	Tendon, achilles, elongation of			Orthopaedic Operations
3995	Tendon, achilles, repair of			Orthopaedic Operations
4000	Tendon transplants about the ankle joint and foot (multiple)			Orthopaedic Operations
4005	Tendon transplants about the ankle joint and foot (single)			Orthopaedic Operations
4010	Traumatic fracture and dislocation, open reduction of			Orthopaedic Operations
4015	Unstable ankle, Watson Jones operation for			Orthopaedic Operations
4019	Astragalectomy			Orthopaedic Operations
4020	Dwyer's Valgus osteotomy			Orthopaedic Operations
4025	Manipulation and plaster fixation		Daycare	Orthopaedic Operations
4030	Manipulation and strapping		Daycare	Orthopaedic Operations
4035	Rotation osteotomy of tibia			Orthopaedic Operations
4040	Soft tissue release			Orthopaedic Operations
4045	Tarsal osteotomy			Orthopaedic Operations
4050	Tendon transplant, single			Orthopaedic Operations
4051	Tendon transplant, multiple			Orthopaedic Operations
4060	Arthrodesis of all inter phalangeal joints (Lambrinudi), unilateral			Orthopaedic Operations
4061	Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy (I.P.)		I.P.	Orthopaedic Operations - Foot
4062	Arthroscopy, metacarpophalangeal joint, surgical, with debridement (I.P.)		I.P.	Orthopaedic Operations - Foot
4063	Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (e.g. Stenar lesion) (I.P.)		I.P.	Orthopaedic Operations - Foot
4065	Arthrodesis of all inter phalangeal joints (Lambrinudi), bilateral			Orthopaedic Operations
4070	Arthrodesis of first metatarso phalangeal joint (I.P.)		(I.P.)	Orthopaedic Operations
4075	Arthrodesis triple, in all its forms			Orthopaedic Operations
4080	Arthrodesis, pantalar			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
4085	Claw foot (Steindlar), muscle stripping, operations for			Orthopaedic Operations
4090	Exostosis of first metatarsal, unilateral, removal of	This code cannot be charged in conjunction with code 4095, 4182, 4184		Orthopaedic Operations
4095	Exostosis of first metatarsal, bilateral, removal of	This code cannot be charged in conjunction with code 4090, 4182, 4184		Orthopaedic Operations
4100	Flat foot involving joint fusion, operation for			Orthopaedic Operations
4101	Flexor tenotomy, single (foot)		Daycare	Orthopaedic Operations
4102	Flexor tenotomy, multiple (foot)		Daycare	Orthopaedic Operations
4103	Fracture of hindfoot, internal fixation, unilateral			Orthopaedic Operations
4104	Fracture of hindfoot, internal fixation, bilateral			Orthopaedic Operations
4105	Fracture of phalanges and/or metatarsals, closed reduction of (I.P.)		(I.P.) , Daycare	Orthopaedic Operations
4106	Open treatment (hindfoot) of calcaneal or talus fracture with or without internal or external fixation			Orthopaedic Operations
4107	Percutaneous skeletal fixation of metatarsal fracture with manipulation			Orthopaedic Operations
4108	Open treatment of metatarsal fracture, with or without internal or external fixation			Orthopaedic Operations
4110	Fracture of phalanx and/or metatarsal, single, internal fixation of	This code cannot be charged in conjunction with code 4135		Orthopaedic Operations
4115	Fracture of phalanges and/or metatarsals, multiple, internal fixation of			Orthopaedic Operations
4120	Ganglion of foot, excision of		Daycare	Orthopaedic Operations
4125	Hallux valgus and follow up, other than simple removal of exostosis, unilateral operation for			Orthopaedic Operations
4130	Hallux valgus and follow up, other than simple removal of exostosis, bilateral, operation for			Orthopaedic Operations
4135	Hammertoe, unilateral, correction of	This code cannot be charged in conjunction with code 4110, max. 1 night hospital stay		Orthopaedic Operations
4140	Hammertoe, bilateral, correction of			Orthopaedic Operations
4145	Grice's operation, subtalar bone block			Orthopaedic Operations
4161	Initial pledget insertion for infected ingrowing toe nail, under general anaesthetic, in children under 16 years of age (I.P.)		(I.P.) , Daycare, Service	Orthopaedic Operations
4162	Tarsal tunnel release (posterior tibial nerve decompression)			Orthopaedic Operations
4170	Laprau's operation to correct position of toe			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
4175	Metatarsal heads, excision of all, and plastic correction of sole, unilateral			Orthopaedic Operations
4180	Metatarsal heads, excision of all, and plastic correction of sole, bilateral, (Hoffman's)			Orthopaedic Operations
4181	Metatarsal joint replacement with prosthesis (IP)		(I.P.)	Orthopaedic Operations
4182	Metatarsal osteotomy, unilateral	This code cannot be charged in conjunction with code 4090, 4095, 4184		Orthopaedic Operations
4183	Metatarsal osteotomies, bilateral			Orthopaedic Operations
4184	Chevron osteotomy, single	This code cannot be charged in conjunction with code 4090, 4095, 4182. Max 1 night hospital stay		Orthopaedic Operations
4185	Os calcis, osteotomy of (Dwyer)			Orthopaedic Operations
4190	Os calcis and bursa, posterior exostosis of, unilateral removal of			Orthopaedic Operations
4195	Os calcis and bursa, posterior exostosis of, bilateral, removal of			Orthopaedic Operations
4200	Plantar fascia, excision or division of, unilateral			Skin & Subcutaneous Tissues
4205	Plantar fascia, excision or division of, bilateral			Skin & Subcutaneous Tissues
4206	Extracorpeal shock wave, high energy	Must be performed by a consultant, with or without anaesthesia or pain control, involving the plantar fascia to a maximum of 3 sessions and after documented evidence of other modality failure (orthosis, physiotherapy and injections)		Skin & Subcutaneous Tissues
4215	Stamm's operation, unilateral			Orthopaedic Operations
4220	Stamm's operation, bilateral			Orthopaedic Operations
4225	Talectomy			Orthopaedic Operations
4230	Tarsal osteotomy			Orthopaedic Operations
4235	Tendon transplantation about the foot, multiple			Orthopaedic Operations
4240	Tendon transplantation about the foot, single			Orthopaedic Operations
4245	Tendon transplantation, flexor and extensor all toes, unilateral			Orthopaedic Operations
4250	Tendon transplantation, flexor and extensor all toes, bilateral			Orthopaedic Operations
4255	Trans metatarsal amputation of foot			Orthopaedic Operations
4260	Trans metatarsal amputation of one toe			Orthopaedic Operations
4261	Trans metatarsal amputation of two or more toes			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
4263	Chemodenervation of muscle(s); extremity(ies) and/or trunk muscle(s) (e.g. for dystonia, cerebral palsy, multiple sclerosis)			Orthopaedic Operations
4264	Arthroscopy (not otherwise specified) (IP)		(I.P.) , Diagnostic	Orthopaedic Operations
4265	Arthrotomy for removal of loose bodies			Orthopaedic Operations
4270	Biopsy of tumour of long bones, open		Diagnostic	Orthopaedic Operations
4271	Costotransversectomy			Orthopaedic Operations
4272	Excision of large malignant bone tumours for limb conservation			Orthopaedic Operations
4273	Excision of large malignant bone tumours for limb conservation including prosthetic insertion			Orthopaedic Operations
4275	Application of body cast (surgery benefit includes removal)		Daycare	Orthopaedic Operations
4280	Bone cysts (long bones only), excision			Orthopaedic Operations
4281	Bone marrow aspiration		Diagnostic, Daycare	Skin & Subcutaneous Tissues
4282	Bone marrow biopsy		Diagnostic	Skin & Subcutaneous Tissues
4285	Bursectomy, large joints		Daycare	Orthopaedic Operations
4286	Bone marrow harvesting (I.P.)		(I.P.)	Skin & Subcutaneous Tissues
4287	Bone marrow aspiration and biopsy		Diagnostic	Skin & Subcutaneous Tissues
4288	Peripheral blood stem cell harvesting (I.P.)		(I.P.)	Skin & Subcutaneous Tissues
4290	Chondroma, removal		Daycare	Skin & Subcutaneous Tissues
4293	Allogeneic bone marrow transplantation or blood derived peripheral stem cell transplantation, for patients with acute leukaemia, chronic leukaemia, severe aplastic anaemia, myelodysplasia or multiple myeloma; all inclusive benefit for in-patient and out-patient treatment for a three month period			Skin & Subcutaneous Tissues
4294	Matched unrelated donor bone marrow transplantation or blood derived peripheral stem cell transplantation for patients with acute leukaemia, chronic leukaemia, severe aplastic anaemia, myelodysplasia or multiple myeloma; all inclusive benefit for in-patient and out-patient treatment for a three month period			Skin & Subcutaneous Tissues
4295	Exostosis of long bones, removal			Orthopaedic Operations
4296	Autologous bone marrow transplantation or blood derived peripheral stem cell transplantation, for patients with acute leukaemia, chronic leukaemia, non-Hodgkins lymphoma, Hodgkins disease or multiple myeloma; all inclusive benefit for in-patient and out-patient treatment for a three month period			Skin & Subcutaneous Tissues

Code	Description	Payment Rules	Payment Indicators	Speciality
4298	High dose chemotherapy with autologous stem cell rescue, for children with high risk brain tumour: all inclusive benefits for in patient attendence, stem cell harvesting and chemotherapy; claimable once per treatment cycle			Skin & Subcutaneous Tissues
4300	Fracture sternum and ribs, operative reduction			Orthopaedic Operations
4301	Limb lengthening (upper or lower limb) including osteotomy procedure and application of fixator devices			Orthopaedic Operations
4305	Long bones, sequestrectomy, decortication or bone graft (IP)		(I.P.)	Orthopaedic Operations
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)			Orthopaedic Operations
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)			Orthopaedic Operations
4308	Adjustment or revision of (uniplane or multiplane) external fixation system requiring general anaesthetic			Orthopaedic Operations
4309	External fixation system (uniplane or multiplane as in procedure codes 4306 and 4307) removal under general anaesthetic			Orthopaedic Operations
4310	Osteomyelitis, drilling of bones			Orthopaedic Operations
4315	Osteomyelitis, marsupialisation and bone grafting		Daycare	Orthopaedic Operations
4320	Removal of plates, pins, screws; superficial (includes removal of sternum wire) (I.P.)		(I.P.) , Daycare	Orthopaedic Operations
4321	Arthrocentesis, one or more injections at the same session, children aged 12 to 16; small, intermediate or large joint (I.P.)		(I.P.) , Daycare, Service	Orthopaedic Operations
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.)		(I.P.) , Daycare, Service	Orthopaedic Operations
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.)		(I.P.) , Daycare, Service	Orthopaedic Operations
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.)		(I.P.) , Daycare, Service	Orthopaedic Operations
4325	Removal of plates, pins, screws; deep dissection through muscle into bone requiring layered repair of incision (I.P.)		(I.P.) , Daycare	Orthopaedic Operations
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.)		(I.P.) , Daycare, Service	Orthopaedic Operations
4330	Trimming of stump following amputation of limb			Orthopaedic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
4331	Injection, tendon sheath, ligament, or ganglion cyst (I.P.)		(I.P.) , Side Room, Service	Orthopaedic Operations
4337	Debridement of wound, which may include skin, or subcutaneous tissue or muscle less than 9% of body surface			Plastic Surgery
4338	Debridement of wound, which may include skin, or subcutaneous tissue or muscle between 9% and 18% of body surface			Plastic Surgery
4339	Debridement of wound includes skin, and/or subcutaneous tissue, and/or muscle greater than 18% of body surface			Plastic Surgery
4341	Debridement and skin grafting of wound less than 9% of body surface; includes excision of open wound, burn eschar or scar excision			Plastic Surgery
4342	Debridement and skin grafting of wound between 9% and 18% of body surface; includes excision of open wound, burn eschar or scar excision			Plastic Surgery
4343	Debridement and skin grafting of wound greater than 18% of body surface; includes excision of open wound, burn eschar or scar excision			Plastic Surgery
4371	Escharotomy			Plastic Surgery
4372	Acellular dermal replacement;first 100sq.cm. or less, or 1% of body area of infants and children	For codes 4372 and 4373 a comprehensive report must be provided on the claim form detailing body area and square cm involved.		Plastic Surgery
4373	Acellular dermal replacement; each additional 100sq. cm. or each additional 1% of body area of infants and children	For codes 4372 and 4373 a comprehensive report must be provided on the claim form detailing body area and square cm involved.		Plastic Surgery
4385	Inlay grafts (ankle)			Plastic Surgery
4395	Inlay grafts (fingers)			Plastic Surgery
4400	Inlay grafts (knee)			Plastic Surgery
4405	Scar excisions (per scar) flexion, fingers, elbows, groin, knees		Daycare	Plastic Surgery
4410	Z plasty (per scar) flexion, fingers, elbows, groin, knees		Daycare	Plastic Surgery
4415	Adjustment of lip margin			Plastic Surgery
4420	Adjustment of scars, secondary			Plastic Surgery
4425	Cleft palate reconstruction			Plastic Surgery
4430	Complete cleft lip and anterior palate repair			Plastic Surgery
4431	Primary repair, unilateral cleft lip			Plastic Surgery
4432	Primary repair, bilateral cleft lip			Plastic Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
4433	Secondary repair, unilateral cleft lip			Plastic Surgery
4434	Secondary repair, bilateral cleft lip		Daycare	Plastic Surgery
4440	Fistula, secondary closure of			Plastic Surgery
4460	Maxillary bone graft			Plastic Surgery
4465	Nostril margin, secondary correction of			Plastic Surgery
4466	Total cleft rhinoplasty			Plastic Surgery
4470	Pharyngoplasty (not for snoring)			Plastic Surgery
4475	Soft palate partial cleft, reconstruction of			Plastic Surgery
4476	Mastopexy to contralateral breast (at same operative session as mastectomy for other breast) includes full thickness graft from other areas. (List separately in addition to code for primary procedure. Benefit shown is payable in full with code for the primary procedure)			Plastic Surgery - Breast Reconstruction
4477	Breast reconstruction with free flap, post-mastectomy			Plastic Surgery
44771	Breast reconstruction with free flap, post-mastectomy Diep (deep inferior epigastric perforators) - Upper end **pre-authorisation required**	Paid at 100% in conjunction with code 44772		Plastic Surgery
44772	Breast reconstruction with free flap, post-mastectomy Diep (deep inferior epigastric perforators) - Lowe end **pre-authorisation required**	Paid at 100% in conjunction with code 44771		Plastic Surgery
44773	Free Fat injection, post mastectomy **pre-authorisation required**	For correction of breast defect post breast reconstruction surgery (non cosmetic). Limit of 1 per lifetime	Independent Procedure	Plastic Surgery
4478	Breast reconstruction with pedicled transverse rectus abdominis myocutaneous flap (TRAM)			Plastic Surgery
4479	Nipple reconstruction post mastectomy		Daycare	Plastic Surgery
4480	Breast reduction (Unilateral) **Pre-authorisation required**	See note below		Plastic Surgery
Benefit for payment for Breast reduction will be provided in the following circumstances:1. BMI < 25 2. Bra cup size >/=F 3. Symptoms: (a) 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. (b) Acromio-clavicular syndrome				
44480	Breast reduction - Bilateral **pre-authorisation required**	See note below		Plastic Surgery
Benefit for payment for Breast reduction will be provided in the following circumstances: 1. BMI < 25 2. Bra cup size >/=F 3. Symptoms: (a) 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. (b) Acromio-clavicular syndrome				
4482	Plastic repair of inverted nipple		Daycare	Plastic Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
4484	Mastopexy including full thickness graft from other areas post mastectomy (I.P.)	Post Mastectomy Only		Plastic Surgery
4485	Breast reconstruction, vertical rectus flap, post mastectomy	Post Mastectomy Only		Plastic Surgery
4486	Breast reconstruction, latissimus dorsi flap, with or without implant, post mastectomy	Post Mastectomy Only		Plastic Surgery
4487	Breast reconstruction, other flap, with or without implant, post mastectomy	Post Mastectomy Only		Plastic Surgery
4488	Mammoplasty, augmentation with prosthetic implant to restore symmetry **Pre-authorisation required**	See note below		Plastic Surgery
Benefit for corrective surgery for breast asymmetry will be provided in the following circumstances: 1. 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 or 2. Restoration of symmetry following mastectomy				
4489	Facial trauma, suturing of facial nerve			Plastic Surgery
4491	Facial trauma, suturing of facial nerve branch			Plastic Surgery
4492	Facial trauma, grafting of facial nerve, sural nerve, greater auricular nerve			Plastic Surgery
4493	Excision of facial nerve and graft, sural nerve, greater auricular nerve			Plastic Surgery
4494	Wedge excision of lower lip to restore oral continence in the presence of facial palsy		Side Room	Plastic Surgery
4496	Nasolabial skin/dermal hitch			Plastic Surgery
4497	Temporalis fascial sling, oral, nasolabial, ocular			Plastic Surgery
4498	Orbicularis oris hitch			Plastic Surgery
4499	Masseter to oral angle, digastric to lower lip or temporalis to fascial slings			Plastic Surgery
4500	Facial nerve graft (in face), (see E.N.T. operations for facial nerve graft in facial canal)			Plastic Surgery
4501	Cross facial nerve grafting, hypoglossal/facial nerve reanimation			Plastic Surgery
4502	Free muscle transfer, pectoralis minor, gracilis or extensor digitorum brevis as a second stage procedure to 4501			Plastic Surgery
4504	Nipple - areola tattooing performed by a consultant (one or more visits)	Benefit payable following breast reconstruction procedures which were eligible for Aviva benefit and when carried out by Consultant Plastic Surgeon registered with Aviva	Side Room, Service	Plastic Surgery
4510	Facial reanimation in facial paralysis, unilateral			Plastic Surgery
4513	Free skin and/or muscle flap with microvascular anastomosis			Plastic Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
4514	Free osteocutaneous flap with microvascular anastomosis, any area			Plastic Surgery
4525	Rhinoplasty (I.P.)	Max. 1 Night Hospital Stay	I.P.	Ear, Nose & Throat
4538	Treatment of superficial wound dehiscence; simple closure with or without packing (single layer closure)		Service	Plastic Surgery
4539	Secondary closure of surgical wound or dehiscence, (post infectious breakdown) includes excision of granulation and scar tissue; suturing in several layers, extensive site		(I.P.) , Service	Plastic Surgery
4541	Skin grafting of granulating wound less than 9% of body surface			Plastic Surgery
4542	Skin grafting of wound between 9% and 18% of body surface			Plastic Surgery
4543	Skin grafting of wound greater than 18% of body surface			Plastic Surgery
4544	Keloids and hypertrophic scars intralesional injection of triamcinolone, extensive, seven or more lesions or one lesion larger than 5 sq cm where general anaesthetic is medically necessary; by Consultant Plastic Surgeon registered with Aviva only (I.P.)		Independent Procedure, Side Room, Service	Plastic Surgery
45461	Keloids and hypertrophic scars intralesional injection of triamcinolone; up to and including the sixth lesions , Under 12 in an Aviva approved hospital(I.P.)		I.P., Side room, service	Plastic Surgery
4547	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen; infraumbilical panniculectomy **Pre-authorisation required**	See note below		Plastic Surgery
Benefit is payable for procedure code 4547 only in the following circumstances: (a) For members who have had bariatric surgery for which AVIVA 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 appropiate medical therapy, or remains refractory to appropiate medical therapy over a period of 3 months. Pre certification required.				
4551	Insertion of tissue expanders (other than breast) includes subsequent expansion(s)			Plastic Surgery
4552	Removal of expander (other than breast)			Plastic Surgery
4553	Removal of expander (other than breast) and inserting of expanded skin			Plastic Surgery
4554	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction			Plastic Surgery
4555	Accessory auricles, removal		Daycare	Plastic Surgery
4556	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction			Plastic Surgery
4557	Replacement of tissue expander with permanent prosthesis			Plastic Surgery
4560	Epithelioma of ear, excision and reconstruction, lobule placement		Side Room	Plastic Surgery
4561	Cartilage graft(s), reconstruction of ear			Plastic Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
4575	Protruding ears, correction with reconstruction of folds, bilateral	Benefit only payable for patients up to eighteen years of age	Dacare	Plastic Surgery
4580	Protruding ears, correction of with reconstruction of folds, unilateral	Benefit only payable for patients up to eighteen years of age	Daycare	Plastic Surgery
4585	Contracted socket			Plastic Surgery
4595	Enophthalmos, bone graft			Plastic Surgery
4605	Decompression, orbit			Plastic Surgery
4610	Eyebrow graft			Plastic Surgery
4615	Eyelids, repair of, for avulsion			Plastic Surgery
4620	Eyelid, inlay grafts (one lid)		Daycare	Plastic Surgery
4625	Eyelid operations in facial paralysis	Visual fields must be supplied with claim form		Plastic Surgery
4630	Eyelid, total reconstruction of		Daycare	Plastic Surgery
4635	Muscle advancement for ptosis, unilateral		Daycare	Plastic Surgery
4640	Naso lacrimal duct, reconstruction of			Plastic Surgery
4645	Closure of bladder exstrophy			Urology Procedures
4660	Epispadias, reconstruction of urethra			Urology Procedures
4670	Hypospadias, fistula closure			Urology Procedures
4675	Hypospadias, reconstruction of urethra			Urology Procedures
4676	One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap			Urology Procedures
4681	Insertion of malleable penile prosthesis **Pre-authorisation required**	See note below		Urology Procedures

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. 2 The Clinical conditions considered appropriate for the use of such prosthesis are : Post radical prostatectomy, post cystectomy, post major colonic / colorectal surgery, post radiotherapy / cancer treatment to penis/ prostate/ testes, for person suffering with Type 1 diabetes. 2. The Clinical Indicators in respect of this 3rd line therapy is following at least 3 years of erectile disfunction following failure of 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 and where the patient will have undergone a prolonged course of Psychiatric evaluation and advice and/or including medication. 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)

Code	Description	Payment Rules	Payment Indicators	Speciality
4682	Insertion of inflatable penile prosthesis **Pre-authorisation required**	See note below		Urology Procedures
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. 2 The Clinical conditions considered appropriate for the use of such prosthesis are : Post radical prostatectomy, post cystectomy, post major colonic / colorectal surgery, post radiotherapy / cancer treatment to penis/ prostate/ testes, for person suffering with Type 1 diabetes. 2. The Clinical Indicators in respect of this 3rd line therapy is following at least 3 years of erectile disfunction following failure of 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 and where the patient will have undergone a prolonged course of Psychiatric evaluation and advice and/or including medication. 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)				
4686	Cliteroplasty			Plastic Surgery
4690	Vaginal reconstruction with skin graft			Plastic Surgery
4691	Young - Dees operation			Urology Procedures
4695	Congenital hand deformities, reconstruction on each hand (per stage)			Plastic Surgery
4700	Congenital hand deformities, moderate repairs on each hand (per stage)		Daycare	Plastic Surgery
4705	Contractures, extensive, straightening of hand and inlay grafts			Plastic Surgery
4710	Contractures, localised, division and graft			Plastic Surgery
4711	Dermofasciectomy, removal of flexor skin, full thickness skin graft including distal or full palm, one finger			Plastic Surgery
4712	Dermofasciectomy, removal of flexor skin, full thickness skin graft including distal or full palm, one finger including simple fasciectomy to another finger			Plastic Surgery
4715	Dupuytren's contracture,fasciectomy (one or two fingers)	Max. 1 Night Hospital Stay		Plastic Surgery
4720	Dupuytren's contracture, fasciectomy (three or more fingers)	Max. 1 Night Hospital Stay		Plastic Surgery
4721	Dupuytren's contracture, palm and fingers	Max. 1 Night Hospital Stay		Plastic Surgery
4722	Dupuytren's contracture, using Collagenase Clostridium Histolyticum (Xiapex), palms and fingers		Independent Procedure, Daycare, Service	Plastic Surgery
4730	Injury to hand, major, multiple repair of tendons, nerves and skin			Plastic Surgery
4735	Injury to hand, moderate, wound repair or graft			Plastic Surgery
4740	Island grafting, for sensory loss, finger and/or thumb			Plastic Surgery
4745	Neoplasm, major excision and repair with tendon grafts and flaps			Plastic Surgery
4750	Neoplasm, localised excision and graft		Daycare	Plastic Surgery
4760	Nerve repair, primary, single or multiple			Plastic Surgery
4765	Nerve repair in extensively scarred hand			Plastic Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
4770	Opposition strut graft to thumb			Plastic Surgery
4775	Palmar ganglion, compound, synovectomy of		Daycare	Plastic Surgery
4780	Policisation (finger replacement of lost thumb)			Plastic Surgery
4781	Repair of bifid thumb			Plastic Surgery
4782	Toe to hand transfer			Plastic Surgery
4783	Sympathectomy, digital arteries, each digit with magnification			Plastic Surgery
4785	Syndactyly, repair of, single			Plastic Surgery
4790	Syndactyly, repair of, multiple			Plastic Surgery
4795	Tendon grafting, single			Plastic Surgery
4800	Tendon grafting, multiple			Plastic Surgery
4805	Tendon repair, single			Plastic Surgery
4810	Tendon repair, multiple			Plastic Surgery
4815	Tendon transplants, for restoration of opposition			Plastic Surgery
4820	Tendon transfers for paralysis, multiple			Plastic Surgery
4825	Tube pedicle or flap reconstructions, first stage			Plastic Surgery
4830	Tube pedicle or flap reconstructions, second stage			Plastic Surgery
4835	Tube pedicle or flap reconstructions, final stage			Plastic Surgery
4836	Release of syndactyly; toes (I.P.)		(I.P.)	Plastic Surgery
4845	Facial bone, simple fixation of undisplaced fracture (e.g. jaw sling)			Plastic Surgery
4850	Facial bones, tumours of, major resection and/or reconstruction			Plastic Surgery
4855	Fracture of maxilla or mandible, open reduction and fixation			Plastic Surgery
4860	Fracture of maxilla or mandible, fixation of undisplaced			Plastic Surgery
4865	Fracture of maxilla or mandible, malar bone or part of these, reduction without fixation			Plastic Surgery
4870	Hypertelorism correction, sub cranial			Plastic Surgery
4875	Mandible, excision of			Plastic Surgery
4880	Maxilla or mandible, advancement or recession osteotomy of			Plastic Surgery
4881	Maxillary and mandibular osteotomy			Plastic Surgery
4882	Lengthening of the mandible by gradual distraction for congenital hemifacial microsomia **Pre-authorisation required**			Plastic Surgery
4883	Surgically assisted rapid maxillary expansion **Pre-authorisation required**			Plastic Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
4885	Orbital floor, fracture of, reduction, direct wiring and build up from antrum			Plastic Surgery
4890	Orbital floor, secondary bone grafting			Plastic Surgery
4895	Osteomyelitis or abscess of facial bones, operation for		Daycare	Plastic Surgery
4900	Temporo mandibular joint, reduction of dislocation under general anaesthetic		Daycare	Plastic Surgery
4901	Arthroscopy, temporo mandibular joint for release of adhesions or arthroplasty, with or without biopsy		Daycare, Service	Plastic Surgery
4905	Temporo mandibular joint, condylectomy for ankylosis			Plastic Surgery
4910	Bone graft			Plastic Surgery
4915	Nasal tip deformities, correction of			Plastic Surgery
4920	Fracture of nose, digital closed reduction		Daycare	Plastic Surgery
4925	Fracture of nose, instrumental closed reduction		Daycare	Plastic Surgery
4926	Fracture of nose, instrumental closed reduction with plaster of Paris fixation		Daycare	Plastic Surgery
4927	Fracture of nose, instrumental closed reduction with reduction of septum and plaster of Paris fixation		Daycare	Plastic Surgery
4930	Fracture of nose, open reduction		Daycare	Plastic Surgery
4935	Fracture of nose, open reduction with internal or external fixation		Daycare	Plastic Surgery
4937	Excision of benign or malignant lesion(s), any area; adjacent tissue transfers or rearrangement, 4 sq. cm or less	See note below	Side Room Only	Plastic Surgery - Local Flaps & Grafts
Payable only 1. for Z- plasty, W plasty, V-Y plasty, local flap, transposition flap, distant distortion flap, random island flap, advancement flap. NOTE: Undermining done of adjacent tissue to achieve closure, without additional incision, does not constitute adjacent tissue transfer. 2 Skin grafting where necessary to close secondary defect is considered an additional procedure (codes 4942,4943 , 4946). This is applicable to a constant with relevant specialist training in this area and registered as such with Aviva				
4938	Excision of benign or malignant lesion(s), any area; adjacent tissue transfer or rearrangement, 4.1 sq. cm to 10 sq. cm	See note below	Sideroom Only	Plastic Surgery - Local Flaps & Grafts
Payable only 1. for Z- plasty, W plasty, V-Y plasty, local flap, transposition flap, distant distortion flap, random island flap, advancement flap. NOTE: Undermining done of adjacent tissue to achieve closure, without additional incision, does not constitute adjacent tissue transfer. 2 Skin grafting where necessary to close secondary defect is considered an additional procedure (codes 4942,4943 , 4946). This is applicable to a constant with relevant specialist training in this area and registered as such with Aviva				
4939	Excision of benign or malignant lesion(s), any area; adjacent tissue transfers or rearrangement, 10.1 sq. cm to 30 sq. cm	See note below	Day Care	Plastic Surgery - Local Flaps & Grafts
Payable only 1. for Z- plasty, W plasty, V-Y plasty, local flap, transposition flap, distant distortion flap, random island flap, advancement flap. NOTE: Undermining done of adjacent tissue to achieve closure, without additional incision, does not constitute adjacent tissue transfer. 2 Skin grafting where necessary to close secondary defect is considered an additional procedure (codes 4942,4943 , 4946). This is applicable to a constant with relevant specialist training in this area and registered as such with Aviva				
4940	Fracture of nose, open reduction with open reduction of fractured septum			Plastic Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
4941	Excision of benign or malignant lesion(s), any area; adjacent tissue transfer or rearrangement, 30.1 sq. cm or larger	See note below	Day Care	Plastic Surgery - Local Flaps & Grafts
Payable only 1. for Z- plasty, W plasty, V-Y plasty, local flap, transposition flap, distant distortion flap, random island flap, advancement flap. NOTE: Undermining done of adjacent tissue to achieve closure, without additional incision, does not constitute adjacent tissue transfer. 2 Skin grafting where necessary to close secondary defect is considered an additional procedure (codes 4942,4943 , 4946). This is applicable to a constant with relevant specialist training in this area and registered as such with Aviva				
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)	See note below		Plastic Surgery - Local Flaps & Grafts
The donor site for the grafting material must be specified. Payable only 1. for Z- plasty, W plasty, V-Y plasty, local flap, transposition flap, distant distortion flap, random island flap, advancement flap. NOTE: Undermining done of adjacent tissue to achieve closure, without additional incision, does not constitute adjacent tissue transfer. 2 Skin grafting where necessary to close secondary defect is considered an additional procedure (codes 4942,4943 , 4946). This is applicable to a constant with relevant specialist training in this area and registered as such with Aviva				
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)	See note below		Plastic Surgery - Local Flaps & Grafts
The donor site for the grafting material must be specified. Payable only 1. for Z- plasty, W plasty, V-Y plasty, local flap, transposition flap, distant distortion flap, random island flap, advancement flap. NOTE: Undermining done of adjacent tissue to achieve closure, without additional incision, does not constitute adjacent tissue transfer. 2 Skin grafting where necessary to close secondary defect is considered an additional procedure (codes 4942,4943 , 4946). This is applicable to a constant with relevant specialist training in this area and registered as such with Aviva				
4944	Excision of pressure sore and myocutaneous flap			Plastic Surgery
4945	Reconstruction with imported flaps, partial			Plastic Surgery
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 note after procedure 4946)	See note below		Plastic Surgery - Local Flaps & Grafts
The donor site for the grafting material must be specified. Payable only 1. for Z- plasty, W plasty, V-Y plasty, local flap, transposition flap, distant distortion flap, random island flap, advancement flap. NOTE: Undermining done of adjacent tissue to achieve closure, without additional incision, does not constitute adjacent tissue transfer. 2 Skin grafting where necessary to close secondary defect is considered an additional procedure (codes 4942,4943 , 4946). This is applicable to a constant with relevant specialist training in this area and registered as such with Aviva				
4947	Large lipoma requiring removal under general anaesthetic measuring 4cm, deep to deep facia requiring surgery by Consultant Plastic Surgeon			Plastic Surgery - Cutaneous Flaps
4949	Excision of pressure sore and local cutaneous flap (IP)		(I.P.)	Plastic Surgery
4950	Reconstruction with imported flaps, total			Plastic Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
4951	Free flap (microvascular transfer) to face, complete procedure			Plastic Surgery
4952	Excision of pressure sore and split skin graft			Plastic Surgery
4955	Re fracture and open corrective rhinoplasty including nasal tip deformities (code 4915), unless demonstrable evidence discloses significant nasal tip deformity being corrected			Plastic Surgery
4963	Excision of lesion including scalp rotation flap(IP)		(I.P.)	Plastic Surgery
4964	Excision of lesion including cheek rotation flap(IP)		(I.P.)	Plastic Surgery
4966	Excision of lesion including cervicofacial rotation flap(IP)		(I.P.)	Plastic Surgery
4967	Excision of lesion including forehead flap(IP)		(I.P.)	Plastic Surgery
4968	Excision of lesion including deltopectoral flap(IP)		(I.P.)	Plastic Surgery
4969	Excision of lesion including groin flap(IP)		(I.P.)	Plastic Surgery
4971	Fasciocutaneous flap, upper limb(IP)		(I.P.)	Plastic Surgery
4972	Fasciocutaneous flap, lower limb(IP)		(I.P.)	Plastic Surgery
4973	Fasciocutaneous flap, trunk(IP)		(I.P.)	Plastic Surgery
4974	Myocutaneous flap, pectoralis	Flap repair is payable in addition to the primary operation for procedures 4974 and 4982		Plastic Surgery
4976	Myocutaneous flap, latissimus dorsi			Plastic Surgery
4977	Myocutaneous flap, latissimus dorsi with serratus and rib			Plastic Surgery
4978	Myocutaneous flap, vertical rectus			Plastic Surgery
4979	Myocutaneous flap, transverse rectus (TRAM)			Plastic Surgery
4981	Myocutaneous flap, tensor fascia lata			Plastic Surgery
4982	Myocutaneous flap, gluteal	Flap repair is payable in addition to the primary operation for procedures 4974 and 4982		Plastic Surgery
4983	Botox for hyperhydrosis (I.P.)	As a result of a positive Bromide Iodine Starch Test or foll0wing a referral from a Consultant having failed a proscribed course of topical treatment (maximum 2 per annum)	(I.P.)	Plastic Surgery
4990	Major degloving injuries of limbs, excision and graft of			Plastic Surgery
4991	Replantation, per digit			Plastic Surgery
4992	Replantation, hand (mid palm)			Plastic Surgery
4993	Replantation, hand (wrist)			Plastic Surgery
4994	Replantation, forearm			Plastic Surgery
4996	Replantation, foot			Plastic Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
4997	Replantation, scalp following major trauma only			Plastic Surgery
4998	Replantation, ear			Plastic Surgery
4999	Replantation of thumb including carpometacarpal joint to metacarpophalangeal joint, complete amputation, with or without microvascular anastomosis			Plastic Surgery
5008	Cardiac ultrasound, (echocardiography) for patients on cytotoxic chemotherapy	See note below	Diagnostic, Side Room, Service	Cardiological Procedures
5108 and 5008 is not payable in addition to 5109. 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, and 25% of the third highest valued procedure.				
5015	Lung abscess with thoracotomy, drainage of			Thoracic Operations
5021	Major consultant consultation including tilt table testing, alone or in combination with the administration of provocative agents (e.g. Isoproterenol), with continuous ECG monitoring and intermittent blood pressure monitoring for the evaluation of cardiac function in patients with recurrent unexplained neurocardiogenic syncope who have an inconclusive history and physical examination, as well as negative non-invasive tests of cardiac structure and function (not payable for any other indication except as stated above).	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, and 25% of the third highest valued procedure.	Side Room	Cardiological Procedures
5022	Cardiovascular stress test with pharmaceutical/chemical agent(s) includes IV administration, echocardiography ECG with consultant cardiologist in constant attendance.	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: 1% of the highest valued procedure, 5% of the second highest valued procedure, and 25% of the third highest valued procedure.		Cardiological Procedures
5023	Consultant consultation and evaluation including monitoring of cardiovascular status for six hours for a patient commencing a course of oral Gilenya (fingolimod) to treat relapsing forms of multiple sclerosis. The evaluation to include a 12 lead ECG at baseline and 6 hours after first dose; continuous 6 hour ECG monitoring including blood pressure and heart rate measurement every hour		Day Care	Cardiological Procedures
5025	Pneumonolysis			Thoracic Operations
5033	Thoroscopic epicardial radiofrequency ablation; operative tissue ablation with or without reconstruction of atria (e.g. modified maze procedure) without cardiopulmonary bypass (I.P.) (see note)	See note below	I.P.	Thoracic Operations - Heart
Conditions of payment for code 5033 are as follows: 1). 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 2). relevant documentation confirming the above must be provided when the claim is being submitted.				

Code	Description	Payment Rules	Payment Indicators	Speciality
5034	Major consultation and transthoracic echocardiography, initial assessment of an infant or child under 16 with suspected heart disease, for the diagnosis or exclusion of complex congenital or acquired cardiac anomalies or where a detailed follow up examination is indicated. Also for adults with congenital heart disease assessed by a Consultant Paediatric Cardiologist.	See note below		Thoracic Operations
Benefit includes pre-operative or post-operative assessment, or in the follow up of critical or severe heart disease including detailed segmental analysis assessment of visceral situs, 2D M-mode, Doppler (PW,CW and colour flow), assessment of myocardial function, pressure gradients, regurgitation including image acquisition, interpretation and report				
5036	Transthoracic echocardiography for congenital or acquired cardiac anomalies in children under 16; limited study for patients where the cardiac anatomy is known (e.g. follow up of valve stenosis) or in the evaluation or follow up of patients with predominantly non-cardiac problems (e.g. pre or post cancer chemotherapy, severe renal disease, overwhelming sepsis), where the assessment of myocardial and valvular function or exclusion of pericardial effusion is required		Diagnostic, Side Room, Service	Paediatric Cardiology
5037	Transthoracic echocardiography, initial assessment of an infant or child, for the diagnosis or exclusion of complex congenital or acquired cardiac anomalies or where a detailed follow up examination is indicated. Also for adults with congenital heart disease assessed by a Consultant Paediatric Cardiologist.	See note below		Paediatric Cardiology
Benefit includes pre-operative or post-operative assessment, or in the follow up of critical or severe heart disease including detailed segmental analysis assessment of visceral situs, 2D M-mode, Doppler (PW,CW and colour flow), assessment of myocardial function, pressure gradients, regurgitation including image acquisition, interpretation and report				
5038	Refilling and maintenance of implantable pump or reservoir including access to pump port (I.P.)	See note below	I.P., Side Room	Thoracic Operations
For implantation and maintenance of pain pumps, procedure codes 5038 and 5039 if the procedure is performed for one of the following clinical indications - Diffuse cancer pain - Failed back surgery - Osteoporosis - Arachnoiditis - Axial Somatic Pain - Painful neuropathies - Spinal cord injury - Spasticity arising from Multiple Sclerosis or Cerebral Palsy				
5039	Implantation of catheter system and reservoir for administration of pain control therapy and/or chemotherapy (I.P.)	See note below	I.P.	Thoracic Operations
For implantation and maintenance of pain pumps, procedure codes 5038 and 5039 if the procedure is performed for one of the following clinical indications - Diffuse cancer pain - Failed back surgery - Osteoporosis - Arachnoiditis - Axial Somatic Pain - Painful neuropathies - Spinal cord injury - Spasticity arising from Multiple Sclerosis or Cerebral Palsy				
5041	Myocardial biopsy		Diagnostic	Thoracic Operations
5042	Removal of subcutaneous implantable pump or spinal cord stimulator (does not apply to removal of Hickman, Broviac, Vascath or similar) (IP)		(I.P.) , Daycare	Thoracic Operations
5043	Removal of spinal neurostimulator pulse generator or receiver, or neurostimulator electrode percutaneous array(s) or plate/ paddle(s)(I.P.)		(I.P.) , Daycare	Thoracic Operations
5044	Replacement of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s) (IP)		(I.P.) , Daycare	Neurosurgical Operations
5051	Replacement of spinal neurostimulator pulse generator or receiver direct or inductive coupling (I.P.)		(I.P.) , Daycare	Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5053	Subcutaneous implantation of a patient-activated cardiac event loop recorder with memory, activator and programmer, including electronic analysis of implantable loop recorder system (ILR), (includes retrieval of recorded and stored ECG data)	See note below		Cardiological Procedures
Benefit is payable for (1) Patients with a history of syncope who have recurrent but infrequent syncopal episodes, and when the etiology of syncope has not been diagnosed by conventional means. Syncope is defined as a sudden but transient total loss of consciousness with spontaneous resolution. (2) Benefit for subcutaneous implantable cardiac event loop recorder is payable where a definite diagnosis has not been made and where the following conditions have been met. - Complete history and physical examination - ECG - Two negative or non diagnostic 30 pre symptom memory loop patient demand recordings (single/multiple , with/without 24 hour attended monitoring) Only one cardiac loop recorder implantation will be covered for a given patient in any two year period.				
5054	Removal of implantable, patient-activated cardiac event loop recorder (where the original implantation met the conditions of payment)			Cardiological Procedures
5055	Aortic endarterectomy			Thoracic Operations
5056	Insertion of neurostimulator pulse generator and electrodes: sacral nerve for bladder muscle control: trial stage **Pre-authorisation required**	See note below	Day Care	Urology Procedures
Treatment of urge urinary incontinence or symptoms or urge-frequency when all of the following criteria are met (a) 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 (this frequency limits the members ability to participate in activities of daily living) and (b) Pharmacotherapies (i.e. at least 2 different anti-cholinergic drugs or a combination of this and a tricyclic depressant) as well as behavioural treatments and related activities have failed.				
5057	insertion of neurostimulator pulse generator and electrodes: sacral nerve for bladder muscle control: permanent implantation (Hospital stay applies for a maximum of 1 night only. See note **Pre-authorisation required**	Conditions of payment for procedure code 5057 are as follows: 1). 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. 2). Treatment of non-obstructive urinary retention provided test stimulation of the patient satisfies the criteria indicating at least 50% decrease in residual urinary volume.		Thoracic Operations - Heart
5058	Cardiac catheterisation and coronary angiography with or without ventriculography with fractional flow reserve (FFR) intracoronary pressure measurements	See note below	Diagnostic, Daycare	Cardiological Procedures
Please confirm which of the following conditions are met for 1. patients with angina pectoris or other other symptoms triggered by exertion who have a) 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. b) 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 c) Significant perfusion defect in myocardial perfusion scan or finings in exercise echocardiography indicating myocardial ischemia. 2. Patient with acute chest pain with: d) ST elevation myocardial infarction e) non-St segment elevation myocardial infarction and unstable angina pectoris. f) Heart failure of unknown aetiology g) as further investigation in a patient surviving resuscitation after ventricular fibrillation h) In association with invasive assessment of valvular heart disease i) assessment prior to heart transplantation				
5063	Removal of single or dual chamber pacing cardioverter/ defibrillator electrode(s); by transvenous extraction.			Cardiological Procedures

Code	Description	Payment Rules	Payment Indicators	Speciality
5065	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter			Cardiological Procedures
5069	Insertion of automatic implantable cardioverter/ defibrillator, single or dual chamber	See note below		Thoracic Operations
Please indicate which of the following conditions are met on the claim form: 1. 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. 2 Structural heart disease and spontaneous sustained VT, whether hemodynamically stable or unstable. 3 Syncope of undetermined origin with clinically relevant, hemodynamically significant sustained VT or VF induced at EP study. 4 LVEF <35% due to prior MI who are at least 40 days post MI and are in NYHA functional Class 1 or 2. 5 Non ischemic DCM who have LVEF <35% and who are NYHA functional Class 2 or 3. 6 LV dysfunction due to prior MI who are at least 40 days post MI and have an LVEF <30% and are NYHA Class 1. Non sustained VY due top prior MI, LVEF <40% and inducible VF or sustained vT at EP study. Unexpected syncope, significant LV dysfunction and non ischemic DCM. 9 Sustained VT and normal or near normal ventricular function. 10. HCM with one or more risk factors for SCD. 11 Prevention of SCD in patients with ARVD/C who have had one or more factors for SCD. 12 To reduce bet blockers in patients with long QT syndrome who are experience syncope and/or VT receiving beta blocker 13. Non-hospitalised patients awaiting transplantation 14. Patients with Brugada syndrome who have had syncope. 15 Brugada syndrome with documented VT that has not resulted in cardiac arrest. 16 Catecholamingic polymorphic VT with syncope and/or documented sustained VT while receiving beta blockers. 17 Cardiac sarcoidosis, giant cell myocarditis or Chagas disease				
5071	Insertion or replacement of permanent pacemaker with transvenous electrode(s); single chamber .	See note below		Cardiological Procedures
Procedure codes 571, 572, 573 and 574 include repositioning or replacement in the first 14 days after the insertion (or replacement) of the device. For all procedures 553, 563, 569, 5961, 596, 552, 52, 579, 577, 576, 574, 573, 572, 571, 521, 522, 519, 58, 518, 5119, 5115, 5117, 5111, 5116, 5113, 511, 558, 59, 58, 565 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: 1% of the highest valued procedure, 5% of the second highest valued procedure, and 25% of the third highest valued procedure.				
5072	Insertion or replacement of permanent pacemaker with transvenous electrode(s); dual chamber.	See note below		Cardiological Procedures
Procedure codes 571, 572, 573 and 574 include repositioning or replacement in the first 14 days after the insertion (or replacement) of the device. For all procedures 553, 563, 569, 5961, 596, 552, 52, 579, 577, 576, 574, 573, 572, 571, 521, 522, 519, 58, 518, 5119, 5115, 5117, 5111, 5116, 5113, 511, 558, 59, 58, 565 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: 1% of the highest valued procedure, 5% of the second highest valued procedure, and 25% of the third highest valued procedure.				
5073	Insertion or replacement of pacemaker pulse generator only; single chamber atrial or ventricular	Procedure codes 571, 572, 573 and 574 include repositioning or replacement in the first 14 days after the insertion (or replacement) of the device		Cardiological Procedures
5074	Insertion or replacement of pacemaker pulse generator only (includes defibrillator pulse generator); dual chamber	Procedure codes 571, 572, 573 and 574 include repositioning or replacement in the first 14 days after the insertion (or replacement) of the device		Cardiological Procedures
5075	Blalock operation			Thoracic Operations
5076	Insertion, replacement or repositioning of permanent transvenous electrode(s) only (15 days or more after initial insertion); single chamber.			Thoracic Operations
5077	Insertion, replacement or repositioning of permanent transvenous electrode(s) only (15 days or more after initial insertion); dual chamber.			Thoracic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
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).			Cardiological Procedures
5080	Cardiac catheterisation (left, right or both sides) (I.P.)		(I.P.) , Diagnostic, Daycare	Cardiological Procedures
5089	Transoesophageal echocardiography for congenital cardiac anomalies in children under 16 years of age; including probe placement, image acquisition, interpretation and report		Diagnostic, Side Room	Paediatric Cardiology
5090	Cardiac catheterisation and coronary angiography with or without ventriculography.	See note below	Diagnostic, Daycare	Cardiological Procedures
Please confirm which of the following conditions are met for 1. patients with angina pectoris or other other symptoms triggered by exertion who have a) 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. b) 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 c) Significant perfusion defect in myocardial perfusion scan or finings in exercise echocardiography indicating myocardial ischemia. 2. Patient with acute chest pain with: d) ST elevation myocardial infarction e) non-St segment elevation myocardial infarction and unstable angina pectoris. f) Heart failure of unknown aetiology g) as further investigation in a patient surviving resuscitation after ventricular fibrillation h) In association with invasive assessment of valvular heart disease i) assessment prior to heart transplantation				
5091	Cardioversion		Daycare	Thoracic Operations
5092	Venotomy and insertion of filter into the inferior vena cava			Thoracic Operations
5093	Paediatric cardiac catheterisation (left, right or both sides)		Diagnostic	Paediatric Cardiology
5094	Paediatric cardiac catheterisation and cardiac angiography combined		Diagnostic	Paediatric Cardiology
5101	Coronary angioplasty, single or multiple vessel(s), with or without angiography with or without pacing	Max. 1 Night Hospital Stay		Cardiological Procedures
5103	Transcatheter placement of an intracoronary stent (other than drug eluting stents), percutaneous, with or without other therapeutic intervention, with or without angiography, any method, single vessel	Max. 1 Night Hospital Stay		Cardiological Procedures
5108	Cardiac ultrasound, (echocardiography)	See note below	Diagnostic, Service	Cardiological Procedures
5108 and 5008 is not payable in addition to 5109. Code 5108 should not incur a Hospital Technical fee. For all procedures 5053, 5063, 5069, 5961, 5960, 5502, 5200, 5079, 5077, 5076, 5074, 5073, 5072, 5071, 5021, 5022, 5109, 5008, 5108, 5119, 5115, 5117, 5111, 5116, 5113, 5101, 5058, 5090, 5080, 5065 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, and 25% of the third highest valued procedure.				
5109	Echocardiography, transoesophageal, real-time with image documentation (2D) (with or without M-mode recording), including probe placement, image acquisition, interpretation and report	See note below	Diagnostic, Side Room, Service	Cardiological Procedures
5108 and 5008 is not payable in addition to 5109. No benefit is payable for transesophageal echocardiography (5109), when performed intraoperatively. We will consider benefit for this procedure in exeptional circumstances when there is a previous history of a cardiac condition. Such claims will be reviewed on a case by case basis where the attending surgeon provides a separate medical report. For all procedures 5053, 5063, 5069, 5961, 5960, 5502, 5200, 5079, 5077, 5076, 5074, 5073, 5072, 5071, 5021, 5022, 5109, 5008, 5108, 5119, 5115, 5117, 5111, 5116, 5113, 5101, 5058, 5090, 5080, 5065 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, and 25% of the third highest valued procedure.				

Code	Description	Payment Rules	Payment Indicators	Speciality
5110	Thoracoscopy, surgical; with oesophagomyotomy (Heller type)			Thoracic Operations
5111	Transcatheter placement of intracoronary stents (other than drug eluting stents), percutaneous, with or without other therapeutic intervention, with or without angiography, any method, more than one vessel	Max. 1 Night Hospital Stay		Cardiological Procedures
5112	Post bypass cardiac catheterisation and coronary angiography with or without ventriculography (including opacifaction of coronary bypass grafts)	Please contact 1850 718 718 for confirmation		Cardiological Procedures
5113	Pericardial drainage			Thoracic Operations
5114	Continuous pericardial drainage			Thoracic Operations
5115	Percutaneous transcatheter closure of congenital interatrial communication (i.e. Fontan fenestration, atrial septal defect) with implant, including right heart catheterisation.	See note below	Daycare	Cardiological Procedures
Procedure codes 5115 and 5119 include right heart catheterisation. For all procedures 5053, 5063, 5069, 5961, 5960, 5502, 5200, 5079, 5077, 5076, 5074, 5073, 5072, 5071, 5021, 5022, 5109, 5008, 5108, 5119, 5115, 5117, 5111, 5116, 5113, 5101, 5058, 5090, 5080, 5065 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, and 25% of the third highest valued procedure.				
5116	Transcatheter placement of a drug eluting stent, percutaneous, with or without other therapeutic intervention, with or without angiography, any method, single vessel	See note below		Cardiological Procedures
Max. 1 Night Hospital Stay. For all procedures 553, 563, 569, 5961, 596, 552, 52, 579, 577, 576, 574, 573, 572, 571, 521, 522, 519, 58, 518, 5119, 5115, 5117, 5111, 5116, 5113, 511, 558, 59, 58, 565 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: 1% of the highest valued procedure, 5% of the second highest valued procedure, and 25% of the third highest valued procedure.				
5117	Transcatheter placement of drug eluting stents, percutaneous, with or without other therapeutic intervention, with or without angiography, any method, more than one vessel	See note below		Cardiological Procedures
Max. 1 Night Hospital Stay. For all procedures 553, 563, 569, 5961, 596, 552, 52, 579, 577, 576, 574, 573, 572, 571, 521, 522, 519, 58, 518, 5119, 5115, 5117, 5111, 5116, 5113, 511, 558, 59, 58, 565 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: 1% of the highest valued procedure, 5% of the second highest valued procedure, and 25% of the third highest valued procedure.				
5118	Atherectomy			Thoracic Operations
5119	Percutaneous transcatheter closure of congenital ventricular septal defect with implant including right heart catheterisation.	See note below		Cardiological Procedures
Procedure codes 5115 and 5119 include right heart catheterisation. For all procedures 553, 563, 569, 5961, 596, 552, 52, 579, 577, 576, 574, 573, 572, 571, 521, 522, 519, 58, 518, 5119, 5115, 5117, 5111, 5116, 5113, 511, 558, 59, 58, 565 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: 1% of the highest valued procedure, 5% of the second highest valued procedure, and 25% of the third highest valued procedure.v				
5120	Excision of mediastinal tumour			Thoracic Operations
5121	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach			Thoracic Operations
5122	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy			Thoracic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5123	Excision of mediastinal cyst			Thoracic Operations
5124	Mediastinoscopy, with or without biopsy (I.P.)		(I.P.) , Diagnostic	Thoracic Operations
5125	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis (artificial valve) and coronary reconstruction			Thoracic Operations
5126	Transverse arch graft, with cardiopulmonary bypass			Thoracic Operations
5127	Descending thoracic aorta graft, with or without bypass			Thoracic Operations
5128	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass			Thoracic Operations
5131	Open procurement of a radial artery to secure conduit for construction of a coronary artery bypass graft (payable in full with main benefit)	Payable in full with main benefit		Thoracic Operations
5132	Foetal echocardiography for the diagnosis or exclusion of cardiac anomalies in the foetus, including detailed segmental analysis, assessment of visceral situs (2D), M -mode, Doppler (PW & colour flow), assessment of myocardial function, regurgitation - including image acquisition, interpretation and report		Diagnostic, Side Room, Service	Paediatric Cardiology
5133	Transcatheter aortic valve implantation (TAVI) for aortic stenosis (Edwards Sapien) **Pre-authorisation required**	See note below	I.P	Cardiological Procedures
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 Aviva for inclusion on the Aviva list of such facilities			
5134	Operative ablation/incision and/or reconstruction of atria for treatment of atrial fibrillation or flutter (e.g. maze procedure)			Thoracic Operations
5135	Mediastinoscopy and biopsy		Diagnostic	Thoracic Operations
5136	Percutaneous transthoracic biopsy		Diagnostic	Thoracic Operations
5137	Percutaneous transthoracic biopsy under CAT guidance		Diagnostic	Thoracic Operations
5138	Operative ablation of atrial fibrilation, supraventricular arrhythmogenic focus or pathway (eg, Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci) with or without cardiopulmonary bypass			Thoracic Operations
5139	Operative ablation of atrial fibrilation, ventricular arrhythmogenic focus with cardiopulmonary bypass			Thoracic Operations
5141	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular			Thoracic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5142	Removal of single or dual chamber pacing cardioverterdefibrillator electrode(s); by thoracotomy			Thoracic Operations
5143	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass			Thoracic Operations
5144	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; with cardiopulmonary bypass			Thoracic Operations
5146	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension			Thoracic Operations
5147	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with coronary reconstruction			Thoracic Operations
5148	Laparoscopy, surgical, oesophaeagolyotomy (Heller type) with fundoplasty, when performed			Thoracic Operations
5151	Percutaneous trans septal mitral valvuloplasty			Thoracic Operations
5152	Valvuloplasty (other than mitral valvuloplasty)			Thoracic Operations
5156	Coronary Artery bypass graft, vein only , one or more coronary venous grafts			Thoracic Operations
5157	Coronary Artery bypass grafts using venous graft(s) and a single arterial graft			Thoracic Operations
5158	Coronary Artery bypass grafts using venous graft(s) and arterial grafts			Thoracic Operations
5162	Repair, tracheo-oesophageal atresia			Thoracic Operations
5163	Repair, tracheo-oesophageal fistula (TOF) alone (H-fistula)			Thoracic Operations
5164	Repair, tracheo-oesophageal fistula (TOF) and atresia, replacement			Thoracic Operations
5165	Oesophagectomy (all forms including three stages)			Thoracic Operations
5166	Revision Coronary Artery bypass graft, vein only , one or more coronary venous grafts			Thoracic Operations
5167	Revision Coronary Artery bypass grafts using venouus graft(s) and a single arterial graft			Thoracic Operations
5168	Revision Coronary Artery bypass grafts using venouus graft(s) and arterial grafts			Thoracic Operations
5171	Transection of oesophagus with repair, for oesophageal varices			Thoracic Operations
5172	Oesophageal devascularisation			Thoracic Operations
5180	Pott's operation			Thoracic Operations
5190	Rashkind septostomy			Thoracic Operations
5200	Transeptal left heart catheterisation.	See note below		Cardiological Procedures

For all procedures 553, 563, 569, 5961, 596, 552, 52, 579, 577, 576, 574, 573, 572, 571, 521, 522, 519, 58, 518, 5119, 5115, 5117, 5111, 5116, 5113, 511, 558, 59, 58, 565 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: 1% of the highest valued procedure, 5% of the second highest valued procedure, and 25% of the third highest valued procedure.

Code	Description	Payment Rules	Payment Indicators	Speciality
5205	Vagotomy (through chest)			Thoracic Operations
5217	Needle biopsy, transthoracic		Diagnostic	Thoracic Operations
5218	Needle biopsy, abdominal		Diagnostic	Thoracic Operations
5219	Trans thoracic electro-cautery of subclavian lymph nodes			Thoracic Operations
5221	Closed pleural biopsy		Diagnostic	Thoracic Operations
5223	Insertion of permanent pacemaker with epicardial electrode(s), by thoracotomy			Thoracic Operations
5230	Empyema, drainage of (I.P.)		(I.P.)	Thoracic Operations
5231	Percutaneous drainage of empyema			Thoracic Operations
5234	Paracentesis thoracis (I.P.)		(I.P.) , Diagnostic	Thoracic Operations
5235	Paracentesis thoracis with intercostal drain (I.P.)		(I.P.) , Diagnostic	Thoracic Operations
5245	Phrenic avulsion (I.P.)		(I.P.)	Thoracic Operations
5250	Pleurodesis			Thoracic Operations
5251	Closed drainage of pneumothorax			Thoracic Operations
5260	Thoracoscopy (I.P.)		(I.P.) , Diagnostic	Thoracic Operations
5265	Thoracoscopy with intrapleural procedure			Thoracic Operations
5270	Thoracotomy including lung or pleural biopsy (I.P.)		(I.P.) , Diagnostic	Thoracic Operations
5274	Exploration for post-operative haemorrhage or thrombosis, chest			Thoracic Operations
5290	Clipping aneurysm, anterior circulation			Neurosurgical Operations
5292	Detachable balloon occlusion of carotico cavernous aneurysms and fistulae			Neurosurgical Operations
5295	Craniectomy or craniotomy for cerebellar haematoma			Neurosurgical Operations
5320	Craniectomy for excision of brain tumour, supratentorial			Neurosurgical Operations
5325	Penetrating brain injury with removal foreign body			Neurosurgical Operations
5365	Craniectomy for meningioma, supratentorial			Neurosurgical Operations
5370	CSF leak repair			Neurosurgical Operations
5376	Craniotomy for excision epileptic focus			Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5377	Craniotomy for lobectomy (epilepsy) with electrocorticography during surgery (includes removal of electrode array)			Neurosurgical Operations
5378	Craniotomy with elevation of bone flap (for intractable epileptic seizures); for lobectomy, temporal, temporallobe, without electrocorticiography during surgery.			Neurosurgical Operations
5379	Craniotomy with elevation of bone flap (to treat intractable mesial temporal lobe epilepsy); for selective amygdalohippocampectomy			Neurosurgical Operations
5400	Hemispherectomy			Neurosurgical Operations
5410	Craniectomy or craniotomy for intracerebral haematoma			Neurosurgical Operations
5420	Craniectomy or craniotomy for abscess			Neurosurgical Operations
5470	Craniotomy for removal of pituitary tumour or to resection a portion of gland			Neurosurgical Operations
5484	Stereotactic computer assisted volumetric intracranial procedure	Payable in full with main benefit		Neurosurgical Operations
5490	Burr hole for excavation and/or drainage of subdural haematoma			Neurosurgical Operations
5502	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, HIS bundle recording, including insertion and repositioning of multiple electrode catheters.	See note below		Cardiological Procedures
For all procedures 553, 563, 569, 5961, 596, 552, 52, 579, 577, 576, 574, 573, 572, 571, 521, 522, 519, 58, 518, 5119, 5115, 5117, 5111, 5116, 5113, 511, 558, 59, 58, 565 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: 1% of the highest valued procedure, 5% of the second highest valued procedure, and 25% of the third highest valued procedure.				
5520	Shunt insertion			Neurosurgical Operations
5525	Shunt revision			Neurosurgical Operations
5575	Injection of trigeminal ganglion or nerve under image guidance(IP)		(I.P.) , Daycare	Neurosurgical Operations
5580	Destruction by radiofrequency lesioning of trigeminal ganglion under x-ray guidance via foramen ovale (IP)		(I.P.) , Daycare	Neurosurgical Operations
5586	Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve (eg for blepharospasm, hemifacial spasm)			Neurosurgical Operations
5590	Intracranial sensory root division (trigeminal)			Neurosurgical Operations
5600	Peripheral nerve repairs			Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5605	Peripheral nerve tumour, excision of			Neurosurgical Operations
5606	Implantation of neurostimulator electrodes, Vagus nerve			Neurosurgical Operations
5607	All inclusive benefit for Cyber Knife surgery: one or more sessions, including evaluation of all digitised data, target outline, radiation treatment planning and CT scan evaluation volumetric analysis -Radiotherapists Benefit **Pre-authorisation required**	See note below		Stereotactic Radiosurgery
1. Small symptomatic arterio-venous malformations < 3cm. 2 Trigeminal neuralgia following referral by a consultant neurologist and when the condition had persisted for at least 6 months despite treatment with pharmacotherapies (carbamazepine, phenytoin and ballofen) or the member is unable to tolerate the side effects of medication 3. meningioma's, excluding the initial treatment of those with a cortical or spinal location. 4 Acoustic neuroma / vestibular schwannoma <3 cm. Primary malignant spinal tumours where surgery is not an option and conventional radiotherapy is not appropriate because of the dose limitation to the spine. Benefit will only be provided following a multi-disciplinary team meeting at a nominated Aviva hospitals, where such team includes the attendance of a neuro-radiation oncologist				
5608	All inclusive benefit for Cyber Knife surgery: one or more sessions, including evaluation of all digitised data, target outline, radiation treatment planning and CT scan evaluation volumetric analysis -Neurosurgeons Benefit **Pre-authorisation required**	See note below		Stereotactic Radiosurgery
Pre-Cert Conditions of Payment for procedure codes 5607 and 5608 are as follows: 1). Small symptomatic arterio-venous malformations less than 3 cm 2). Trigeminal neuralgia following referral by a consultant neurologist recognised by Aviva Health and when the condition has persisted for at least six months despite conservative treatment with pharmacotherapies (carbamazepine, phenytoin and baclofen) or the member is unable to tolerate the side effects of the medications 3). Meningioma's, excluding the initial treatment of those with a cortical or spinal location 4). Acoustic neuroma / vestibular schwannoma less than or equal to 3 cm 5). primary malignant spinal tumours where surgery is not an option and conventional radiotherapy is not appropiate because of teh dose limitations to the spine. benefit will only be provided following discussion at a multi-disciplinary meeting at Beaumont Hospital that involver a neuroradation oncologist.				
5610	Sensory nerve, neurectomy			Neurosurgical Operations
5611	Injection, anaesthetic agent and/or steroid or other substance medial branch (facet) or dorsal root ganglion, one or more levels under image guidance (IP)		(I.P.) , Daycare	Neurosurgical Operations
5612	Non destructive pulse radiofrequency (PRF) lesioning medial branch (facet) or dorsal root ganglion, one or more levels under image guidance(IP)		(I.P.) , Daycare	Neurosurgical Operations
5614	Peripheral nerve lesioning including pulsed radiofrequency or electrical stimulation (I.P.)		(I.P.) , Daycare	Neurosurgical Operations
5615	Peripheral nerve block for pain control using nerve stimulation or ultrasound (I.P.)		(I.P.) , Side Room	Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5616	Neurodestructive thermal rhizotomy (temperature > 69°C), under image guidance, with sensory and motor testing, one or more levels, lumbar, sacral or thoracic (IP)	See note below	Daycare	Neurosurgical Operations
The following information must be provided on the claim form before benefit can be considered for payment: DetailS of the level(s) that were treated by rhizotomy ie. L4/5 or L5/S1 and whether this was carried out on the left or right side of the spine and confirm the temperature used to perform the procedure.				
5617	Neurodestructive thermal rhizotomy (temperature >69°C), under image guidance, with sensory and motor testing, one or more levels, cervical(IP)	See note below	I.P., Daycare	Neurosurgical Operations
The following information must be provided on the claim form before benefit can be considered for payment: DetailS of the level(s) that were treated by rhizotomy ie. L4/5 or L5/S1 and whether this was carried out on the left or right side of the spine and confirm the temperature used to perform the procedure.				
5618	Repeat of procedure 5616 to the same anatomical site, one or more levels, lumbar, sacral or thoracic (I.P.)	See note below	I.P., Daycare	Neurosurgical Operations
The following information must be provided on the claim form before benefit can be considered for payment: DetailS of the level(s) that were treated by rhizotomy ie. L4/5 or L5/S1 and whether this was carried out on the left or right side of the spine and confirm the temperature used to perform the procedure.				
5619	Repeat of procedure 5617 to the same anatomicla site, one or mpre levels, cervival (I.P.)	See note below	I.P., Daycare	Neurosurgical Operations
The following information must be provided on the claim form before benefit can be considered for payment: DetailS of the level(s) that were treated by rhizotomy ie. L4/5 or L5/S1 and whether this was carried out on the left or right side of the spine and confirm the temperature used to perform the procedure.				
5620	Sympathetic block, under image guidance(IP)		(I.P.) , Daycare	Neurosurgical Operations
5621	Intravenous block (Bier's technique)(IP)		(I.P.) , Daycare	Neurosurgical Operations
5622	E.C.T. (each session)		Daycare	Neurosurgical Operations
5624	Injection, anaesthetic agent, intercostal nerve, single (I.P.)		(I.P.) , Daycare	Neurosurgical Operations
5625	Injection, anaesthetic agent, intercostal nerve, multiple, regional block (I.P.)		(I.P.) , Daycare	Neurosurgical Operations
5626	Radiotherapy Patient Treatment Management Radical Programe - Breast			Radiotherapy
5627	Radiotherapy Patient Treatment Management Radical Programe - Prostate			Radiotherapy
5628	Radiotherapy Patient Treatment Management Radical Programe - Rectum			Radiotherapy
5629	Radiotherapy Patient Treatment Management Radical Programe - Brain			Radiotherapy
5630	Repair of cirsoid aneurysm of the scalp			Plastic Surgery
5631	Radiotherapy Patient Treatment Management Radical Programe - Gynaecological(cervix; endometrium; vulva; vagina; ovaries)			Radiotherapy

Code	Description	Payment Rules	Payment Indicators	Speciality
5632	Radiotherapy Patient Treatment Management Radical Programe - Oesophagus, pre operative radiation			Radiotherapy
5633	Radiotherapy Patient Treatment Management Radical Programe - Oesophagus, primary radiation therapy(Oesophagus not surgically removed)			Radiotherapy
5634	Radiotherapy Patient Treatment Management Radical Programe - Stomach			Radiotherapy
5636	Radiotherapy Patient Treatment Management Radical Programe - Anal Canal			Radiotherapy
5637	Radiotherapy Patient Treatment Management Radical Programe - Pancreas Post Operative			Radiotherapy
5638	Radiotherapy Patient Treatment Management Radical Programe - Pancreas, primary radiation therapy (Pancreas not surgically removed)			Radiotherapy
5639	Radiotherapy Patient Treatment Management Radical Programe - Lymphoma			Radiotherapy
5641	Radiotherapy Patient Treatment Management Radical Programe - Sarcoma			Radiotherapy
5642	Radiotherapy Patient Treatment Management Radical Programe - Skin			Radiotherapy
5643	Radical programme for sites not listed - Simulation and treatment planning (standard) less than 15 treatments			Radiotherapy
5644	Radical programme for sites not listed - Simulation and treatment planning (standard) 16 to 25 treatments			Radiotherapy
5645	Burr hole(s) for brain biopsy/abscess tapping		Diagnostic	Neurosurgical Operations
5646	Radical programme for sites not listed - Simulation and treatment planning (standard) 26 to 30 treatments			Radiotherapy
5647	Radical programme for sites not listed - Simulation and treatment planning (standard) 31 to 35 treatments			Radiotherapy
5648	Radical programme for sites not listed - Simulation and treatment planning (intermediate) less than 15 treatments			Radiotherapy
5649	Radical programme for sites not listed - Simulation and treatment planning (intermediate) 16 to 25 treatments			Radiotherapy
5650	Burr hole for ventricular puncture or intense care monitoring (I.P.)		(I.P.)	Neurosurgical Operations
5651	Radical programme for sites not listed - Simulation and treatment planning (intermediate) 26 to 30 treatments			Radiotherapy
5652	Radical programme for sites not listed - Simulation and treatment planning (intermediate) 31 to 35 treatments			Radiotherapy
5653	Radical programme for sites not listed - Simulation and treatment planning (3 dimensional) 16 to 25 treatments			Radiotherapy

Code	Description	Payment Rules	Payment Indicators	Speciality
5654	Radical programme for sites not listed - Simulation and treatment planning (3 dimensional) 26 to 30 treatments			Radiotherapy
5656	Radical programme for sites not listed - Simulation and treatment planning (3 dimensional) 31 to 35 treatments			Radiotherapy
5657	Palliation 5 or less fractions			Radiotherapy
5658	Palliation 6 or more fractions			Radiotherapy
5659	Brachytherapy - High Dose Radiation, Intracavitary cylinder insertion non operative; insertion of a single applicator without the need for operative placement			Brachytherapy
5661	Brachytherapy - High Dose Radiation, Intracavitary gynaecological device inserted in theatre.			Brachytherapy
5662	Intraluminal - Endobronchial; oesophagus or bile duct; Insertion of applicator in theatre.			Brachytherapy
5663	Interstitial needles insertion for Brachytherapy into tumours neccessitating a surgical procedure in theatre under anaesthesic - Breast			Brachytherapy
5664	Interstitial needles insertion for Brachytherapy into tumours neccessitating a surgical procedure in theatre under anaesthesic - Head & Neck			Brachytherapy
5665	Elevation depressed skull fracture			Neurosurgical Operations
5666	Interstitial needles insertion for Brachytherapy into tumours neccessitating a surgical procedure in theatre under anaesthesic - Gynaecological			Brachytherapy
5667	Interstitial needles insertion for Brachytherapy into tumours neccessitating a surgical procedure in theatre under anaesthesic - Ano-rectal			Brachytherapy
5668	Interstitial needles insertion for Brachytherapy into tumours neccessitating a surgical procedure in theatre under anaesthesic - Sarcoma			Brachytherapy
5669	Generation of complex computerised plan or CAT planning with homogeneity criteria assessment/ min-max pint assessment and Brachytherapy treatment. Removal of needles when course is completed - Breast			Brachytherapy
5671	Generation of complex computerised plan or CAT planning with homogeneity criteria assessment/ min-max pint assessment and Brachytherapy treatment. Removal of needles when course is completed - Head & Neck			Brachytherapy
5672	Generation of complex computerised plan or CAT planning with homogeneity criteria assessment/ min-max pint assessment and Brachytherapy treatment. Removal of needles when course is completed - Gynaecological			Brachytherapy

Code	Description	Payment Rules	Payment Indicators	Speciality
5673	Generation of complex computerised plan or CAT planning with homogeneity criteria assessment/ min-max pint assessment and Brachytherapy treatment. Removal of needles when course is completed -Ano-rectal			Brachytherapy
5674	Generation of complex computerised plan or CAT planning with homogeneity criteria assessment/ min-max pint assessment and Brachytherapy treatment. Removal of needles when course is completed - Sarcoma			Brachytherapy
5676	Brachytherapy Low Dose Rdaiation(LDR) - Interoperative implant of non cynlinder intracavity device			Brachytherapy
5677	Brachytherapy Low Dose Rdaiation (LDR) - planning review and treatment delivery. Seclectron, multiple treatment fractions			Brachytherapy
5678	Interstitial iridium needles insertion (LDR), including tube placement in theatre under anaesthetic, manual placment of each needle, dose calculations and material preparation			Brachytherapy
5679	Surface application Brachytherapy, planning review and application of treatment - per treatment			Brachytherapy
5681	Radical programme for sites not listed - Simulation and treatment planning (3 Dimensional) less than 15 treatments			Radiotherapy
5682	High dose radiation brachytherapy (HDR) gynaecological (no surgery case).			Brachytherapy
5683	High dose radiation brachytherapy (HDR) Post hysterectomy		Daycare	Brachytherapy
5684	High dose radiation brachytherapy (HDR) to prostate,			Brachytherapy
5686	High dose radiation brachytherapy(HDR) primary treatment for intact breast			Brachytherapy
5687	High dose radiation brachytherapy(HDR) primary treatment post mastectomy		Daycare	Brachytherapy
5688	Subsequent brachytherapy (HDR)treatment session post mastectomy case		Daycare	Brachytherapy
5689	High dose radiation brachytherapy interstitial,(eg head and neck)			Brachytherapy
5690	Osteoma calvarium, excision of			Neurosurgical Operations
5691	Consultant plastic surgeon, cranio facialplasty, including the correction of craniosynostoses and facial synostoses			Neurosurgical Operations
5692	Consultant neurosurgeon, neurosurgical involvement with cranio facialplasty			Neurosurgical Operations
5693	Skull bone grafting to facial skeleton			Neurosurgical Operations
5695	Platybasia, repair of			Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5696	High dose radiation brachytherapy (HDR), bronchus, benefit for placement of treatment applicators, computerised planning, dosimetry and initial treatment session		Daycare	Brachytherapy
5697	Subsequent brachytherapy (HDR) treatment session (bronchus)		Daycare	Brachytherapy
5698	High dose radiation oesophagusl, all inclusive benefit for placement of treatment applicators , computerisd planning, dosimetry and initial treatment session.		Daycare	Brachytherapy
5701	Subsequent brachytherapy oesophagus treatment session		Daycare	Brachytherapy
5703	High dose radiation brachytherapy (HDR), primary treatment for intact breast, consultant radiologist present during the procedure for a localisation of tumour bed and positioning of catheter under ultrasound image guidance.			Brachytherapy
5704	Radiotherapy Patient Treatment Management Radical Programe - Breast (bilateral)			Radiotherapy
5706	Twist drill, burr hole, craniotomy or craniectomy with sterotactic implantation of nuerostimulator electrode array in subcortical site (e.g. Thalmus, globus pallidus, subthalamic, nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording			Neurosurgical Operations
5707	Twist drill, burr hole, craniotomy or craniectomy with sterotactic implantation of nuerostimulator electrode array in subcortical site (e.g. Thalmus, globus pallidus, subthalamic, nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording			Neurosurgical Operations
5708	Revision or removal of intracranial nuerostimular electodes			Neurosurgical Operations
5709	Required course of radiotherapy for patients with symptoms of rejection of a transplanted organ(s) e.g. heart/lung			Radiotherapy
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	Code 5711 is not claimable with Code 5712		Neurosurgical Operations
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	Code 5712 is not claimable with Code 5711		Neurosurgical Operations
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)	Benefit is payable in full when performed with code 5711 or 5712		Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5719	Chemical sympathectomy, lumbar or coeliac plexus under image guidance (I.P.)		(I.P.)	Neurosurgical Operations
5721	Microneurosurgical subarticular fenestration and foramanal decompression including microdisectomy surgery using a microscope; with dynamic stablisation interspinous implant; more than one level (unilateral or bilateral)			Neurosurgical Operations
5722	Microneurosergical subarticular fenestration and foraminal decompression including microdisectemy surgery using a microscope with dynamic stablisation interspinous implant; re-exploration following previous surgery at the same interspace site(s), one or more levels (unilateral or bilateral)			Neurosurgical Operations
5724	Microneurosurgical subarticular fenestration and foraminal decompression including microdiscectomy surgery using a microscope with dynamice stabilisation interspinous implant; one level (unilateral or bilateral)			Neurosurgical Operations
5725	Anomalies of cord vascular, operation for			Neurosurgical Operations
5726	Detailed prostate volume study under ultrasound guidance with immediate transperineal placement of needles/catheters into prostate with multiple interstitial radioelement seed application with real time planning allowing dose/seed adjustment as necessary, with or without cytoscopy	Radio-therapist Benefit		Brachytherapy
5727	Detailed prostate tumour study by transrectal ultrasound includes planning and modelling immediately followed by transrectal/fluoroscopic guidance for transperineal placement of needles/catheters with real time planning, dose mapping and adjustment as necessary	Radiologist Benefit		Brachytherapy
5728	Microneurosurgical subarticular fenestration and foraminal decompression including microdisectomy surgery using a microscope; more than one level (unilateral or bilateral)			Neurosurgical Operations
57281	Microneurosurgical far lateral disc removal (one or more levels) (I.P.)		I.P.	Neurosurgical Operations
5729	Microneurosurgical subarticular fenestration and foraminal decompression including microdisectomy surgery using a microscope; re-exploration following previous surgery at the same interspace site(s), one or more levels (unilateral or bilateral)	Code 5729 cannot be charged in combination with any of codes 5728 or 5732, and can only be charged if performed in conjunction with either code 3598 or 3601		Neurosurgical Operations
5730	Cervical disc, partial excision of (including the insertion of intervertebral cage(s)), including the opening of the posterior longitudinal ligament and foraminotomy to expose and decompress the nerve roots and spinal cord. This code should not be used when part of the disc is removed, without exposure of the dura, as part of a fusion procedure, In that circumstance the code 3601 or 3598 should be used in isolation			Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5731	Cervical disc, excision of two or more levels (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) including the opening of the posterior longitudinal ligament and foraminotomy to expose and decompress the nerve roots and spinal cord.	This code should not be used when part of the disc is removed, without exposure of the dura, as part of a fusion procedure. In that circumstance the code 3601 or 3598 should be used in isolation		Neurosurgical Operations
5732	Microneurosurgical subarticular fenestration and foraminal decompression including microdiscectomy surgery: on one or more levels, unilateral or bilateral			Neurosurgical Operations
5733	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications			Radiotherapy
5734	Radiological imaging IGRT; KV and MV imaging during a radical course of IMRT radiotherapy only where fiducial markers have been placed.			Radiotherapy
5738	Radiological imaging IGRT; in conjunction with external beam treatments where fiducial markers have been placed			Radiotherapy
5741	Intraoperative neurophysiology testing by a Consultant Neurophysiologist to monitor motor evoked potentials/ sensory evoked potentials of the spinal cord during spinal surgery.			Neurosurgical Operations
5743	Botulinum toxin injection for treatment of cervical dystonia		Side Room	Neurosurgical Operations
5744	Burr hole(s) for brain biopsy/abscess tapping/implanting ventricular catheter, reservoir, EEG electrode(s) or pressure recording device			Neurosurgical Operations
5747	Craniectomy or craniotomy, exploratory, supratentorial (I.P.)		(I.P.)	Neurosurgical Operations
5748	Craniectomy or craniotomy, exploratory, infratentorial (I.P.)		(I.P.)	Neurosurgical Operations
5749	Craniectomy or craniotomy for extra/subdural haematoma			Neurosurgical Operations
5751	Craniectomy for foramen magnum decompression (A-C; syringo)			Neurosurgical Operations
5752	Craniectomy for nerve section/decompression			Neurosurgical Operations
5753	Craniectomy for bone tumour, supratentorial			Neurosurgical Operations
5754	Craniectomy for excision of brain tumour, infratentorial			Neurosurgical Operations
5756	Intrathecal cytotoxic chemotherapy infusion		Side Room	Neurosurgical Operations
5757	Craniectomy for meningioma, infratentorial			Neurosurgical Operations
5758	Craniectomy for CP angle tumour (includes acoustic neuroma)			Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5759	Craniectomy for midline skull base tumour			Neurosurgical Operations
5760	Lumbar puncture (I.P.)		(I.P.) , Diagnostic	Neurosurgical Operations
5761	Cervical sympathectomy, unilateral			Neurosurgical Operations
5762	Cervical sympathectomy, bilateral			Neurosurgical Operations
5763	Exploration of the brachial plexus with removal of tumours			Neurosurgical Operations
5764	Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring			Neurosurgical Operations
5765	Lumbar sympathectomy, unilateral			Neurosurgical Operations
5766	Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue			Neurosurgical Operations
5767	Craniotomy for transection of corpus callosum			Neurosurgical Operations
5768	Craniectomy for excision/fenestration cyst			Neurosurgical Operations
5769	Craniotomy for excision of craniopharyngioma (complete removal)			Neurosurgical Operations
5770	Lumbar sympathectomy, bilateral			Neurosurgical Operations
5771	Nerve root tumours, transthoracic or abdominal removal			Neurosurgical Operations
5772	Transnasal or transseptal approach to remove a pituitary tumour or resect a portion of gland			Neurosurgical Operations
5773	Repair of encephalocoele, skull vault, including cranioplasty			Neurosurgical Operations
5774	Craniectomy for repair of skull base, encephalocoele			Neurosurgical Operations
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			Neurosurgical Operations
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			Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5778	Transcochlear 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			Neurosurgical Operations
5779	Arteriovenous malformation, simple (<Spetzler 3)			Neurosurgical Operations
5781	Arteriovenous malformation, complex (>Spetzler 3)			Neurosurgical Operations
5782	Dural arteriovenous malformation			Neurosurgical Operations
5783	Clipping aneurysm, posterior circulation			Neurosurgical Operations
5784	Anastomosis, arterial, extracranial-intracranial (e.g., middle cerebral/cortical) arteries			Neurosurgical Operations
5786	Stereotactic lesioning (functional)			Neurosurgical Operations
5787	Stereotactic biopsy (CAT or MRI targeted)			Neurosurgical Operations
5788	Cranioplasty for skull defect (I.P.)		(I.P.)	Neurosurgical Operations
5789	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion (I.P.)		(I.P.)	Neurosurgical Operations
5791	Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s) (I.P.)		(I.P.)	Neurosurgical Operations
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.)		(I.P.)	Neurosurgical Operations
5793	Percutaneous implantation of neurostimulator electrodes for faecal incontinence; trial phase (Hospital benefits apply for a maximum stay of one night only)			Neurosurgical Operations
5793	Percutaneous implantation of neurostimulator pulse generator and electrodes: faecal incontinence: trial stage **pre-authorisation required**	One night maximum		Urology Procedures
5794	Percutaneous implantation of neurostimulator electrodes for faecal incontinence; permanent implantation			Neurosurgical Operations
5796	Shunt removal			Neurosurgical Operations
5797	Endoscopic third ventriculostomy or cyst fenestration			Neurosurgical Operations
5798	Costovertebral approach with decompression of spinal cord or nerve root(s); thoracic			Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5799	Arthrodesis, anterior interbody fusion (ALIF)			Neurosurgical Operations
5801	Exploration of mediastinum		Diagnostic	Thoracic Operations
5802	Endoscopic extirpation of lesion of mediastinum		Diagnostic	Thoracic Operations
5804	Operation on lymphatic duct			Thoracic Operations
5808	Transplantation of heart			Thoracic Operations
5809	Correction of tetralogy of fallot			Thoracic Operations
5811	Atrial inversion for transposition of great vessels			Thoracic Operations
5812	Other correction of transposition of great vessels			Thoracic Operations
5813	Correction of total anomalous pulmonary venous connection			Thoracic Operations
5814	Closure of defect of atrioventricular septum using dual prosthetic patches			Thoracic Operations
5816	Closure of defect of interatrial septum			Thoracic Operations
5817	Closure of defect of interventricular septum			Thoracic Operations
5818	Planned repair of post infarction ventricular septal defect			Thoracic Operations
5819	Emergency repair of post infarction ventricular septal defect			Thoracic Operations
5821	Other open operations on the septum of the heart			Thoracic Operations
5822	Creation of valved cardiac conduit			Thoracic Operations
5823	Creation of other cardiac conduit			Thoracic Operations
5824	Refashioning of atrium (Ebstein's)			Thoracic Operations
5826	Operations on wall of atrium			Thoracic Operations
5827	Excision of cardiac tumour			Thoracic Operations
5828	Staged correction of hypoplastic left heart syndrome, per stage			Thoracic Operations
5829	Replacement of mitral valve (includes valvuloplasty)			Thoracic Operations
5831	Plastic repair of mitral valve			Thoracic Operations
5832	Replacement of aortic valve (includes valvuloplasty)			Thoracic Operations
5833	Replacement of tricuspid valve (includes valvuloplasty)			Thoracic Operations
5834	Replacement of pulmonary valve (includes valvuloplasty valvotomy)			Thoracic Operations
5835	Peritoneal, venous shunt for ascites			Thoracic Operations
5837	Closed valvotomy			Thoracic Operations
5839	Double valves			Thoracic Operations
5840	Oesphageal motility (monometric) studies with or without 24 hour pH recording		Diagnostic, Side Room	Ear, Nose & Throat
5841	Removal of obstruction from structure adjacent to valve of heart			Thoracic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5842	Triple valves			Thoracic Operations
5845	Ileal conduit and bowel anastomosis			Urology Procedures
5852	Correction of anomalous coronary arteries			Thoracic Operations
5854	Map guided surgery for ventricular arrhythmias			Thoracic Operations
5855	Annuloplasty			Thoracic Operations
5857	Left ventricular aneurysmectomy			Thoracic Operations
5859	Insertion, management and removal of ventricular assist device			Thoracic Operations
5861	Insertion, maintenance and removal of aortic counterpulsation balloon pump			Thoracic Operations
5863	Thymectomy			Thoracic Operations
5867	Removal of pacing system with bypass			Thoracic Operations
5870	Myocardial aneurysmyotomy			Thoracic Operations
5871	Open correction of patent ductus arteriosus			Thoracic Operations
5872	Excision of pericardium			Thoracic Operations
5873	Decompression of cardiac tamponade (re operation for bleeding)			Thoracic Operations
5874	Pericardiocentesis			Thoracic Operations
5875	Shoulder replacement prosthesis(IP)		(I.P.)	Orthopaedic Operations
5876	Transthoracic drainage of pericardium			Thoracic Operations
5877	Creation of pericardial window or partial resection for drainage (I.P.)		(I.P.)	Thoracic Operations
5878	Closure of median sternotomy separation with or without debridment (I.P.)		(I.P.)	Thoracic Operations
5879	Correction of truncus arteriosus			Thoracic Operations
5880	EMG - in an approved Aviva Health recognised Laboratory		Diagnostic, Side Room, Service	Neurosurgical Operations
5881	Electromyography study, rectal mucosal sensitivity testing		Diagnostic, Side Room	Neurosurgical Operations
5882	Closed correction of patent ductus arteriosus			Thoracic Operations
5883	Creation of shunt to pulmonary artery from aorta using interposition tube prosthesis			Thoracic Operations
5884	Pulmonary artery banding			Thoracic Operations
5886	Connection to pulmonary artery from aorta			Thoracic Operations
5887	Creation of shunt to pulmonary artery from subclavian artery using interposition tube prosthesis			Thoracic Operations
5888	Connection to pulmonary artery from subclavian artery			Thoracic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5889	Repair of pulmonary artery/PA De Banding			Thoracic Operations
5890	Ligament reconstruction at the knee joint (I.P.)		(I.P.)	Orthopaedic Operations
5891	Ligament reconstruction of the knee joint using autogenous graft (I.P.)		(I.P.)	Orthopaedic Operations
5892	Pulmonary embolectomy			Thoracic Operations
5893	Open operations on pulmonary artery			Thoracic Operations
5894	Extra anatomic bypass of aorta			Thoracic Operations
5900	Cricopharyngeal myotomy (I.P.)		(I.P.)	Thoracic Operations
5905	Video telemetric EEG recordings including full clinical evaluation and placement of sphenoidal electrodes.	For procedure codes 595 and 596 the benefit incorporates all in-patient attendence		Neurosurgical Operations
5906	Video telemetric EEG recordings including full clinical evaluation following placement of sub dural electrodes.	For procedure codes 595 and 596 the benefit incorporates all in-patient attendence		Neurosurgical Operations
5907	Repair of congenital diaphragmatic hernia using thoracic approach in neonates	The anaesthetist benefit is all inclusive of pre-operative and post-operative intensive care. No other anaesthetic or intensive care benefits are payable		Thoracic Operations
5908	Thoracoplasty, one stage			Thoracic Operations
5909	Excision of chest wall tumour including ribs			Thoracic Operations
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	For procedure code 59101 where monitored anaesthesia is required, claims must be supported by a medical report from the consultant anaesthetist outlining the necessity for monitored anaesthesia		Urology Procedures
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 consulant is not prenenst for the duration of the treatment	For procedure code 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 Procedures
59103	Intra Renal flexible ureterorenoscopy for Intra renal stones	Must be in specially approved Aviva Health facility by an approved Aviva Health consultant specialised and trained in the procedure		Urology Procedures
5911	Ureteroscopy & contact lithotripsy with placement/removal of J stent, one or more sessions per hospital stay (I.P.)		(I.P.)	Urology Procedures
5912	Correction of pectus deformity of chest wall			Thoracic Operations
5913	Reconstruction of chest wall			Thoracic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5914	Exploratory thoracotomy			Thoracic Operations
5916	Resection of rib and open drainage of pleural cavity			Thoracic Operations
5917	Repair of rupture of diaphragm			Thoracic Operations
5918	Plication of paralysed diaphragm			Thoracic Operations
5919	Partial excision of trachea			Thoracic Operations
5920	Reconstruction of trachea			Thoracic Operations
5921	Tracheostomy, permanent	For procedure codes 5921 and 5922, where these procedures are performed in an I.C.U. setting, benefit is payable once only during the patient's stay in the intensive care unit		Thoracic Operations
5922	Insertion of mini tracheostomy	For procedure codes 5921 and 5922, where these procedures are performed in an I.C.U. setting, benefit is payable once only during the patient's stay in the intensive care unit		Thoracic Operations
5923	Destruction of lesion of trachea by rigid endoscopy			Thoracic Operations
5924	Dilatation of tracheal stricture by rigid endoscopy			Thoracic Operations
5927	Cervical rib resection for thoracic outlet syndrome			Thoracic Operations
5928	Therapeutic operations on bronchus or lung using rigid bronchoscopy			Thoracic Operations
5929	Arthrodesis, posterior interbody fusion (PLIF)) including the insertion of interbody cage			Neurosurgical Operations
5931	Destruction of lesion of trachea			Thoracic Operations
5932	Dilatation of tracheal stricture			Thoracic Operations
5933	Insertion of vascath or similar for haemodialysis			General Surgical - Dialysis
5934	Removal of spinal bone tumours			Neurosurgical Operations
5936	Dilatation of bronchial stricture by fibreoptic bronchoscopy			Thoracic Operations
5937	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical			Neurosurgical Operations
5941	Total pneumonectomy			Thoracic Operations
5942	Lobectomy of lung (including excision of segment)			Thoracic Operations
5943	Thoracoscopic lung resections			Thoracic Operations
5944	Open excision of lesion of lung			Thoracic Operations
5946	Decortication of pleura or lung			Thoracic Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5947	Removal of lung, with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)			Thoracic Operations
5948	Removal of lung, with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)			Thoracic Operations
5949	Pleurectomy for pneumothorax, open			Thoracic Operations
5951	Endoscopic examination of pleura			Thoracic Operations
5952	Insertion of tube drain into pleural cavity			Thoracic Operations
5953	Introduction of substance into pleural cavity with chest aspiration			Thoracic Operations
5954	Introduction of substance into pleural cavity with chest drain			Thoracic Operations
5957	Revision repair of coarctation of aorta			Thoracic Operations
5958	Revision closure of defect of intra ventricular septum			Thoracic Operations
5959	Revision of Valve surgery			Thoracic Operations
5960	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement.	See note below		Cardiological Procedures
For all procedures 553, 563, 569, 5961, 596, 552, 52, 579, 577, 576, 574, 573, 572, 571, 521, 522, 519, 58, 518, 5119, 5115, 5117, 5111, 5116, 5113, 511, 558, 59, 58, 565 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: 1% of the highest valued procedure, 5% of the second highest valued procedure, and 25% of the third highest valued procedure.				
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) singly or in combination.	See note below		Cardiological Procedures
For all procedures 553, 563, 569, 5961, 596, 552, 52, 579, 577, 576, 574, 573, 572, 571, 521, 522, 519, 58, 518, 5119, 5115, 5117, 5111, 5116, 5113, 511, 558, 59, 58, 565 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: 1% of the highest valued procedure, 5% of the second highest valued procedure, and 25% of the third highest valued procedure.				
5963	Repair of diaphragmatic hernia using thoracic approach			Thoracic Operations
5964	Each additional interspace, cervical			Neurosurgical Operations
5966	General anaesthetic for mould making in preparation for radiotherapy, in children under 16 years of age			Radiotherapy
5967	General anaesthetic for simulator mapping for radiotherapy in children under 16 years of age, one or more sessions			Radiotherapy
5968	General anaesthetic for radiotherapy treatment in children under 16 years of age, per session			Radiotherapy
5969	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic			Neurosurgical Operations

Code	Description	Payment Rules	Payment Indicators	Speciality
5971	Vertebral corpectomy and grafting			Neurosurgical Operations
5972	Laminectomy with drainage of intramedullary cyst/syrinx			Neurosurgical Operations
5973	Laminectomy with release of tethered spinal cord			Neurosurgical Operations
5974	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord			Neurosurgical Operations
5975	Rhinoplasty, primary, including major septal repair including nasal tip deformities (code 4915), unless demonstrable evidence discloses significant nasal tip deformity being corrected	Max 1 night Hospital Stay		Ear, Nose & Throat
5976	Laminectomy for removal/biopsy extramedullary tumour			Neurosurgical Operations
5977	Laminectomy for removal/biopsy intramedullary tumour			Neurosurgical Operations
5978	Repair meningocoele/ myelomeningocoele			Neurosurgical Operations
5979	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural			Neurosurgical Operations
5980	Combined approach tympanoplasty	Max 1 night Hospital Stay		Ear, Nose & Throat
5981	Neuroplasty and/or transposition ulnar nerve		Daycare	Neurosurgical Operations
5982	Total pneumonectomy with lymphadenectomy			Thoracic Operations
5983	Lobectomy of lung (including excision of segment) with lymphadenectomy			Thoracic Operations
5984	Insertion of a spinal cord stimulator - trial stage **pre-authorisation required**	See note below		Neurosurgical Operations

Benefit for the insertion of spinal cord stimulators will be subject to the following criteria being satisfied: (i) Prior approval is sought by a Consultant recognised by Aviva and who also has a Diploma in Pain Medicine. (ii) The procedure is performed in a hospital that : - Is listed in the Aviva Directory of Hospitals and (iii) Benefit will be provided for the trial stage and subsequent implantation for members who satisfy the following criteria: - An observable pathology concordant with the pain complaint - Further corrective surgical interventions are unlikely to relieve the patient's pain - Non interventional or other conservative therapies have failed - Oral medications are not effective or cause intolerable side effects - No untreated chemical dependency exists - Psychological clearance has been obtained through a consultant psychiatrist or clinical psychologist registered wiht the Psychological Sociaty of Ireland - No contra indications to surgery are present (sepsis, coagulopathy) - Trial screening with the proposed therapy is successful (iv) Benefit will be provided for implantation following a successful trial if the procedure is performed for one of the following clinical: - Failed back surgery - complications, including leg pain, from unsuccessful multiple lumbar surgery to repair lower back problems - Reflex sympathetic dystrophy - Arachnoiditis - Radiculopathies - Chronic refractory angina - Painful neuropathies - Spinal cord injury (v) Benefit for a hospital stay of two nights will be provided for the trial stage. Benefit for a three day stay for the implantation stage will be provided. 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 Aviva

Code	Description	Payment Rules	Payment Indicators	Speciality
5985	Complete investigation of 'at risk' patients with allergy/ anaphylaxis requiring food and drug challenge studies (I.P.)	See note below	(I.P.) , Daycare, Service	Skin & Subcutaneous Tissues
One or more of the following indications must be met for benefit - 1. a systemic reaction involving more than one system has occurred already. 2 Clinical history indicates that airway, breathing or blood pressure control has been affected 3. The challenge involves agents (food or drugs) likely to induce severe reactions . 4 Laboratory evidence of sensitisation is present at a disproportionate level 5. Time kinetics of reaction and need for observation dictates that OPD challenge will not resolve a serious concern				
5989	Total body irradiation.			Radiotherapy
5991	All inclusive benefit for stereotactic radiosurgery (linear accelerator) for metastases one or more sessions, including evaluation of all digitised data, target outline, radiation treatment planning, CT scan evaluation volumetric analysis, stereotactic frame placement and removal including one follow-up consultation			Stereotactic Radiosurgery
5992	Stereotactic radiosurgery (linear accelerator) for arteriovenous malformations, acoustic neuromas and deep seated tumours one or more sessions			Stereotactic Radiosurgery
5993	All inclusive benefit for stereotactic radiosurgery (linear accelerator) for metastases one or more sessions, including evaluation of all digitised data, target outline, radiation treatment planning, CT scan evaluation volumetric analysis, stereotactic frame placement and removal including one follow-up consultation			Stereotactic Radiosurgery
5994	Stereotactic radiosurgery (linear accelerator) for arteriovenous malformations, acoustic neuromas and deep seated tumours one or more sessions			Stereotactic Radiosurgery
5995	Transrectal ultrasound for detailed prostate tumour and prostate volume estimation includes modelling and planning for 3-D template guidance for stage two procedure., Clinical indications for the prostate brachytherapy procedures are as follows: 1. PSA < 20ng per ml 2. Prostate mass < 50cc 3. Gleeson score < 8			Brachytherapy
5996	Transrectal and fluroscopic 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. Clinical indications for the prostate brachytherapy procedures are as follows: 1. PSA < 20ng per ml 2. Prostate mass < 50cc 3. Gleeson score < 8			Brachytherapy
5997	Detailed prostate volume study under anaesthesia includes tumour and prostate volume estimation; modelling and planning for second stage radioactive seeds implantation, patient consultation, with or without digital rectal examination. Clinical indications for the prostate brachytherapy procedures are as follows: 1. PSA < 20ng per ml 2. Prostate mass < 50cc 3. Gleeson score < 8			Brachytherapy

Code	Description	Payment Rules	Payment Indicators	Speciality
5999	Insertion of a spinal cord stimulator - Implantation stage **pre-authorisation required**	See note below		Neurosurgical Operations
Benefit for the insertion of spinal cord stimulators will be subject to the following criteria being satisfied: (i) Prior approval is sought by a Consultant recognised by Aviva and who also has a Diploma in Pain Medicine. (ii) The procedure is performed in a hospital that : - Is listed in the Aviva Directory of Hospitals and (iii) Benefit will be provided for the trial stage and subsequent implantation for members who satisfy the following criteria: - An observable pathology concordant with the pain complaint - Further corrective surgical interventions are unlikely to relieve the patient's pain - Non interventional or other conservative therapies have failed - Oral medications are not effective or cause intolerable side effects - No untreated chemical dependency exists - Psychological clearance has been obtained through a consultant psychiatrist or clinical psychologist registered with the Psychological Society of Ireland - No contra indications to surgery are present (sepsis, coagulopathy) - Trial screening with the proposed therapy is successful (iv) Benefit will be provided for implantation following a successful trial if the procedure is performed for one of the following clinical reasons: - Failed back surgery - complications, including leg pain, from unsuccessful multiple lumbar surgery to repair lower back problems - Reflex sympathetic dystrophy - Arachnoiditis - Radiculopathies - Chronic refractory angina - Painful neuropathies - Spinal cord injury (v) Benefit for a hospital stay of two nights will be provided for the trial stage. Benefit for a three day stay for the implantation stage will be provided. 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 Aviva in advance of treatment			
6102	Brain, without contrast material			Anaesthesia
6103	Brain, with contrast material			Anaesthesia
6104	Orbit, sella or outer, middle, or inner ear; without contrast material			Anaesthesia
6106	Orbit, sella or outer, middle, or inner ear; with contrast material			Anaesthesia
6107	Maxillofacial area, without contrast material			Anaesthesia
6108	Maxillofacial area, with contrast material	Procedure codes 614, 616, 617 and 618 are not payable with 612 or 613 if done at the same time		Anaesthesia
6109	Thorax, without contrast material			Anaesthesia
6111	CAT scanning for biopsy or drainage		Side Room	Anaesthesia
6112	Thorax, with contrast material			Anaesthesia
6113	High resolution, lungs			Anaesthesia
6114	Abdomen (including pelvis), without contrast material			Anaesthesia
6116	Abdomen (including pelvis), with contrast material			Anaesthesia
6123	CT Colonography **pre-authorisation required**	See note below		Anaesthesia
CT colonography is subject to prior approval and payable only for the following categories of patients. (1) Patients who have had a previous failed or incomplete colonoscopy (2) Frail or elderly patients who are medically unfit to undergo colonoscopy procedures (3) Patients in whom colonoscopy is contraindicated (4) Diagnostic examination in patients with known or prior colorectal carcinoma and in symptomatic patients with abdominal pain, constipation, anaemia, intestinal obstruction or weight loss; (5) Clinical indications for which we pay for surveillance CT colonography: a) individuals who have two first degree relatives diagnosed with colorectal cancer; and b) individuals who have first degree relatives who developed colorectal cancer before the age of 60 years will be entitled to benefit for CT colonography every 5 years, beginning at age 40 years or 10 years before the age of the youngest affected relative, whichever is the first. For indications at (5) above we will pay an initial CT colonography and, if normal, repeats at five yearly intervals.			
6124	Ablation therapy for reduction or eradication of one or more pulmonary tumour(s)		(I.P.)	Anaesthesia

Code	Description	Payment Rules	Payment Indicators	Speciality
6222	Computed tomographic (CT) coronary angiography, with or without contrast material(s), all sections, including image post processing **pre-authorisation required**	See note below		Anaesthesia
Procedure code 6222 may be claimed by a Consultant Radiologist, Cardiologist or Paediatric Cardiologist with appropriate training in the interpretation of these types of scans. Benefit is payable to the consultant who interprets the results and reports on them and only payable to one consultant. Benefit is not payable for routine screening purposes, and is subject to the conditions of payment outlined below. (a) The CT Coronary Angiography is carried out using a CT of 64 slices or greater, in a facility approved by Aviva. (b) The patient referred for CT Coronary Angiography by an Aviva registered Consultant Cardiologist, Paediatric Cardiologist or Consultant Cardiothoracic Surgeon. (1) To rule out significant coronary stenosis in persons with the following indications; (a) Persons with chest pain who cannot perform or have contraindications to exercise or pharmacological stress testing. (b) Persons with a positive (i.e. > 1 mm ST segment depression) exercise stress test. (2) Evaluation of asymptomatic persons at low pretest probability of coronary heart disease by Framingham risk scoring who have an equivocal exercise or pharmacological stress test- not for routine screening of asymptomatic adults. (3) Pre-operative assessment of persons scheduled to undergo high risk non-cardiac surgery- including emergency operations in the elderly, aortic or other major vascular surgeries, peripheral vascular surgeries and anticipated prolonged surgical procedures with large fluid shifts and/or blood loss involving the abdomen or thorax- where an imaging stress test or invasive coronary angiography is not performed. (4) Preoperative assessment of persons scheduled to undergo high risk noncoronary cardiac surgery including valvular heart disease, congenital heart disease, pericardial disease in lieu of cardiac catherisation as the initial imaging study. (5) Detection and delineation of suspected coronary anomalies in persons with the following indications (a) Young persons (less than 30 years) with suggestive symptoms e.g. angina, syncope, arrhythmia and exertional dyspnoea, without other known aetiology. (b) Infants with suggestive symptoms e.g. dyspnoea, tachypnoea, wheezing, periods of pallor, irritability, diaphoresis, poor feeding and failure to thrive, without other known aetiology. (6) For pulmonary vein mapping and evaluation of the pulmonary veins in persons undergoing pulmonary vein isolation procedure for atrial fibrillation (pre and post ablation procedure) (7) For pulmonary vein mapping in persons needing biventricular pacemaker to accurately identify the coronary veins for lead placement. (8) For evaluating cardiac structures and morphology in congenital heart disease for the following indications (a) Suspected or known Marfan's syndrome (b) Evaluations of sinus venosum atrial-septal defect (c) Kawasaki's disease (d) Anamolous pulmonary venous drainage (e) Pulmonary outflow tract obstruction (f) Persons scheduled or being evaluated for surgical repair of tetralogy of Fallot or other congenital heart disease. (g) Evaluation of other complex congenital heart disease.				
6223	C.T. scanogram of lower limbs (paediatric)			Anaesthesia
6224	C.T. of spine with contrast material			Anaesthesia
6226	Long bones			Anaesthesia
6227	Joints			Anaesthesia
6228	Spine			Anaesthesia
6229	Feet/Hands			Anaesthesia
6230	Magnetic resonance imaging			Anaesthesia
6231	Magnetic resonance imaging with contrast enhancement.			Anaesthesia
6233	Cardiac magnetic resonance imaging (MRI) with or without contrast enhancement **pre-authorisation required**	For procedure code 6233 the clinical indication identifier code 310 must be provided on the invoice. Benefit for procedure code 6233 is subject to the member being referred for cardiac MRI by an Aviva registered Consultant Cardiologist, Paediatrician, Cardiologist or Cardiothroacic surgeon.	Diagnostic	Anaesthesia
6234	Paedriatric cardiac magnetic resonance imaging, for congenital cardiac anomalies in infants and children under 16 years of age		Diagnostic	Anaesthesia
6415	Renogram			Anaesthesia

Code	Description	Payment Rules	Payment Indicators	Speciality
6435	DMSA renal scan			Anaesthesia
6440	Micturating cystogram			Anaesthesia
6445	SPECT DMSA renal scan			Anaesthesia
6676	Placement of fiducial markers for radiation therapy guidance of prostate (via needle, any approach), single or multiple includes ultrasound guidance		Side Room	Anaesthesia
6684	Uterine artery embolisation for fibroids including angiography and fluoroscopy.	See note below		Anaesthesia
The Radiologist who performs the procedure must have specialist embolisation experience or undergone appropriate training and be registered with Aviva - All cases of uterine artery embolisation must be performed in a hospital listed in the Aviva Directory of Hospitals, by a Consultant Radiologist who participates in a primary research program - All cases must be registered on the national register - Benefits are not paid where: a) There is evidence of recent or current genital tract infection b) The patient is unwilling to proceed to a hysterectomy if the embolisation procedure is complicated; c) if the above criteria are not satisfied in full				
6686	Biopsy of focal lesion in the liver, kidney, pancreas or spleen including embolisation (e.g. Gelfoam)		Side Room	Anaesthesia
6687	Biopsy of focal lesion, under CT guidance, in the liver, kidney, pancreas or spleen including embolisation (e.g. gelfoam)		Side Room	Anaesthesia
6688	Radiofrequency ablation of liver tumour(s) including embolisation (e.g. gelfoam)		Side Room	Anaesthesia
6691	Radiofrequency ablation of renal tumour(s) including embolisation (e.g. gelfoam)		Side Room	Anaesthesia
6692	Biopsy of lymph nodes, deep, under CT guidance		Side Room	Anaesthesia
6741	Transcatheter permanent occlusion or embolisation , percutaneous , any method non-central nervous system, head or neck (extracranial, brachiocephalic branch)			Anaesthesia
6742	Transcatheter permanent occlusion or embolisation , percutaneous , any method non-central nervous system, non head or neck (extracranial, brachiocephalic branch)			Anaesthesia
6743	Image-guided percutaneous core needle biopsy, including Consultant Radiologist interpretation and report (ultrasound or stereotactic localisation) (I.P.)		(I.P.) , Side Room	Anaesthesia
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.)		(I.P.) , Side Room	Anaesthesia
6915	Micturating cystogram			Anaesthesia
10034	Anaesthesia - ICU Inpatient Medicine Benefit 1 day stay			In-Patient Attendance & Other Medical Services
10035	Anaesthesia - ICU Inpatient Medicine Benefit 2 day stay			In-Patient Attendance & Other Medical Services
10036	Anaesthesia - ICU Inpatient Medicine Benefit 3 day stay			In-Patient Attendance & Other Medical Services

Code	Description	Payment Rules	Payment Indicators	Speciality
10037	Anaesthesia - ICU Inpatient Medicine Benefit 4 day stay			In-Patient Attendance & Other Medical Services
10038	Anaesthesia - ICU Inpatient Medicine Benefit 5 day stay			In-Patient Attendance & Other Medical Services
10039	Anaesthesia - ICU Inpatient Medicine Benefit 6 day stay			In-Patient Attendance & Other Medical Services
10040	Anaesthesia - ICU Inpatient Medicine Benefit 7 day stay			In-Patient Attendance & Other Medical Services
10041	Anaesthesia - ICU Inpatient Medicine Benefit 8 day stay			In-Patient Attendance & Other Medical Services
10042	Anaesthesia - ICU Inpatient Medicine Benefit 9 day stay			In-Patient Attendance & Other Medical Services
10043	Anaesthesia - ICU Inpatient Medicine Benefit 10 day stay			In-Patient Attendance & Other Medical Services
10044	Anaesthesia - ICU Inpatient Medicine Benefit 11 day stay			In-Patient Attendance & Other Medical Services
10045	Anaesthesia - ICU Inpatient Medicine Benefit 12 day stay			In-Patient Attendance & Other Medical Services
10046	Anaesthesia - ICU Inpatient Medicine Benefit 13 day stay			In-Patient Attendance & Other Medical Services
10047	Anaesthesia - ICU Inpatient Medicine Benefit 14 day stay			In-Patient Attendance & Other Medical Services
10048	Anaesthesia - ICU Inpatient Medicine Benefit 15 day stay			In-Patient Attendance & Other Medical Services
10069	Anaesthesia - ICU Inpatient Medicine Benefit per day after day 15 of stay			In-Patient Attendance & Other Medical Services
11525	Foreign body, deep removal of, by regional or general anaesthetic			Skin & Subcutaneous Tissues
11546	Enucleation of deep or large lipoma, requiring regional or general anaesthetic			Skin & Subcutaneous Tissues
12930	Performed under Local Anaesthesia or by sedation - Buried tooth roots, (includes more than one root) of one tooth, removal of. **pre-authorisation required**		Side Room Pre-authorisation required	Maxillofacial / Dental / Oral Surgery
12935	Performed under Local Anaesthesia or by sedation - Buried tooth roots, (multiple) of teeth, removal of. **pre-authorisation required**		Side Room Pre-authorisation required	Maxillofacial / Dental / Oral Surgery
12940	Performed under Local Anaesthesia or by sedation - Dental cysts of maxilla or mandible		Side Room Pre-authorisation required	Maxillofacial / Dental / Oral Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
12950	Performed under Local Anaesthesia or by sedation - Extraction of teeth (more than six permanent teeth) with or without alveolectomy		Side Room Pre-authorisation required	Maxillofacial / Dental / Oral Surgery
12953	Performed under Local Anaesthesia or by sedation - Gingivectomy, one to four teeth **pre-authorisation required**		Side Room Pre-authorisation required	Maxillofacial / Oral Surgery
12954	Performed under Local Anaesthesia or by sedation - Gingivectomy, five to eleven teeth **pre-authorisation required**		Side Room Pre-authorisation required	Maxillofacial / Oral Surgery
12956	Performed under Local Anaesthesia or by sedation - Gingivectomy, twelve or more teeth **pre-authorisation required**		Side Room Pre-authorisation required	Maxillofacial / Oral Surgery
12973	Performed under Local Anaesthesia or by sedation - Removal of one upper impacted or unerupted tooth **pre-authorisation required**		Side Room Pre-authorisation required	Maxillofacial / Oral / Dental Surgery
12974	Performed under Local Anaesthesia or by sedation - Removal of two upper impacted or unerupted teeth **pre-authorisation required**		Side Room Pre-authorisation required	Maxillofacial / Oral / Dental Surgery
12976	Performed under Local Anaesthesia or by sedation - Removal of one lower impacted or unerupted tooth **pre-authorisation required**		Side Room Pre-authorisation required	Maxillofacial / Oral / Dental Surgery
12977	Performed under Local Anaesthesia or by sedation - Removal of two lower impacted or unerupted teeth **pre-authorisation required**		Side Room Pre-authorisation required	Maxillofacial / Oral / Dental Surgery
12978	Performed under Local Anaesthesia or by sedation - Removal of one impacted or unerupted canine tooth **pre-authorisation required**		Daycare Pre-authorisation required	Maxillofacial / Oral Surgery
12979	Performed under Local Anaesthesia or by sedation - Removal of two impacted or unerupted canine teeth **pre-authorisation required**		Daycare Pre-authorisation required	Maxillofacial / Oral Surgery
12981	Performed under Local Anaesthesia or by sedation - Removal of four or more impacted or unerupted teeth **pre-authorisation required**		Daycare Pre-authorisation required	Maxillofacial / Oral Surgery
12982	Performed under Local Anaesthesia or by sedation - Removal of three impacted or unerupted teeth which includes two lower teeth **pre-authorisation required**		Daycare Pre-authorisation required	Maxillofacial / Oral Surgery

Code	Description	Payment Rules	Payment Indicators	Speciality
12983	Performed under Local Anaesthesia or by sedation - Removal of three impacted or unerupted teeth which includes two upper teeth **pre-authorisation required**		Daycare Pre-authorisation required	Maxillofacial / Oral Surgery
12984	Performed under Local Anaesthesia or by sedation - Removal of one upper and one lower impacted or unerupted tooth **pre-authorisation required**		Daycare Pre-authorisation required	Maxillofacial / Oral Surgery
13005	Performed under Local Anaesthesia or by sedation - Root resection or apicectomy, single, with or without cyst removal and apical curettage		Side Room	Maxillofacial / Oral Surgery
13010	Performed under Local Anaesthesia or by sedation - Root resection or apicectomy, multiple, with or without cyst removal and apical curettage		Side Room	Maxillofacial / Oral Surgery
31301	Application of Plaster of Paris casts as a separate procedure not associated with concurrent surgery under General Anaesthesia			Orthopaedic Operations
66744	Completed radiological examination and evaluation including imaging (mammography and/or ultrasound), and image-guided percutaneous core needle biopsy; where performed on same day by a Consulant Radiologist (I.P.)		(I.P.) , Side Room	Anaesthesia - Radiology Triple Check Assessment

MEDICAL CODES & RATES

Code	Description	Speciality
8400	Acute severe ventilatory failure (PaO2 less than 8 kPa) occurring as an acute event	In-Patient Attendance & Other Medical Services
8401	Acute pulmonary oedema	In-Patient Attendance & Other Medical Services
8405	Life-threatening broncho-pulmonary haemorrhage	In-Patient Attendance & Other Medical Services
8410	Congenital conditions of the newborn associated with acute continuous respiratory distress	In-Patient Attendance & Other Medical Services
8415	Hyaline membrane disease, ventilation and/or CPAP	In-Patient Attendance & Other Medical Services
8420	Pneumothorax or pneumomediastinum necessitating insertion of underwater seal	In-Patient Attendance & Other Medical Services
8425	Acute airway obstruction by foreign body	In-Patient Attendance & Other Medical Services
8430	Acute bronchiolitis in infants	In-Patient Attendance & Other Medical Services
8432	Severe/acute asthma in a child requiring supplemental oxygen therapy	In-Patient Attendance & Other Medical Services
8433	Acute respiratory failure for patients requiring ventilation assist and management with initiation of pressure or volume preset ventilators for assisted or controlled breathing	In-Patient Attendance & Other Medical Services
8435	Acute myocardial infarction	In-Patient Attendance & Other Medical Services
8437	Life threatening rhythm disturbances	In-Patient Attendance & Other Medical Services
8440	Cardiogenic shock	In-Patient Attendance & Other Medical Services
8445	Acute rheumatic heart disease	In-Patient Attendance & Other Medical Services
8450	Congenital conditions of the newborn associated with cyanosis and heart failure	In-Patient Attendance & Other Medical Services
8455	Hypotensive shock	In-Patient Attendance & Other Medical Services

Code	Description	Speciality
8460	Hypertensive crisis	In-Patient Attendance & Other Medical Services
8465	Cardiac arrest	In-Patient Attendance & Other Medical Services
8470	Acute bacterial endocarditis (myocarditis or pericarditis)	In-Patient Attendance & Other Medical Services
8475	Massive gastrointestinal haemorrhage	In-Patient Attendance & Other Medical Services
8480	Acute infantile diarrhoeal disease, causing dehydration and metabolic disturbance	In-Patient Attendance & Other Medical Services
8485	Acute liver failure	In-Patient Attendance & Other Medical Services
8490	Congenital condition of the newborn associated with acute continuous digestive disturbances	In-Patient Attendance & Other Medical Services
8495	Paediatric conditions requiring hyperalimentation	In-Patient Attendance & Other Medical Services
8500	Paediatric necrotising enterocolitis	In-Patient Attendance & Other Medical Services
8501	Intussusception in neonates, diagnosis, resuscitation and medical management prior to referral to a consultant radiologist for closed reduction	In-Patient Attendance & Other Medical Services
8505	Acute vascular lesions affecting CNS requiring immediate intensive investigation: Cerebral haemorrhage, embolism, thrombosis, acute with objective neurological signs Spontaneous subarachnoid haemorrhage	In-Patient Attendance & Other Medical Services
8506	Generalised tonic-clonic seizures with major convulsions occurring	In-Patient Attendance & Other Medical Services
8515	Reye's syndrome	In-Patient Attendance & Other Medical Services
8520	Acute renal failure	In-Patient Attendance & Other Medical Services
8525	Diabetic ketoacidosis	In-Patient Attendance & Other Medical Services
8526	Hyperosmolar nonketotic coma (hyperglycemic) in patients with plasma glucose in the range of 55.5mmol/L and calculated serum osmolality in the region of 385 mOsm/kg., on presentation. The average fluid deficit is 10L	In-Patient Attendance & Other Medical Services
8530	Primary blood dyscrasia or lymphoma with acute manifestations	In-Patient Attendance & Other Medical Services
8535	Septicaemia/endotoxic shock	In-Patient Attendance & Other Medical Services

Code	Description	Speciality
8540	Acute life endangering poisonings requiring high intensity intervention	In-Patient Attendance & Other Medical Services
8541	Total marrow failure, acute manifestations	In-Patient Attendance & Other Medical Services
8545	Major trauma, not involving surgery	In-Patient Attendance & Other Medical Services
8550	Other reasons, by report as notified and approved for benefit by Aviva Health	In-Patient Attendance & Other Medical Services
8551	Complex discharge planning , by a Consultant in Palliative Medicine, including meeting with the patients family and healthcare professionals and planning the patient's future needs	Palliative Medicine
8552	Care provided by a Consultant in Palliative Medicine that requires the intensity of service appropriate in the case of a dying patient in the final days of life	Palliative Medicine
8553	Complex discharge planning , by a Consultant in Palliative Medicine, where the patient is transferred from hospital to a hospice into the care of another a Consultant in Palliative Medicine,	Palliative Medicine
8560	Paediatric malignancies including leukaemia	In-Patient Attendance & Other Medical Services
8565	Hodgkin's disease	In-Patient Attendance & Other Medical Services
8570	Aggressive non-Hodgkin's lymphomas	In-Patient Attendance & Other Medical Services
8575	Testicular and other germ cell tumours	In-Patient Attendance & Other Medical Services
8580	Sarcomas of bone	In-Patient Attendance & Other Medical Services
8585	Ewing's sarcomas and other small blue round-cell tumours	In-Patient Attendance & Other Medical Services
8586	Anorexia Nervosa, severely symptomatic patients with body Weight 75% less than expected whose condition must be stabilised and/or require intensive monitoring for medical problems Including electrolyte imbalances, cardiac arrhythmias, profound hypoglycaemia, self mutilation, impaired capacity for self -care or active suicide ideation	In-Patient Attendance & Other Medical Services
8692	Consultant Geriatrician In-Patient Consultation	Geriatric
8693	Day care Inpatient Management	In-Patient Attendance & Other Medical Services
8694	Consultant Neonatologist or Paediatrician Major In-Patient Consultation	Neonatology
8697	Consultant Neurologist In-Patient Consultation	In-Patient Attendance & Other Medical Services

Code	Description	Speciality
8700	24 Hour E.C.G.	In-Patient Attendance & Other Medical Services
8705	EEG	In-Patient Attendance & Other Medical Services
8706	24 hour in-patient ambulatory EEG; monitoring for localisation of cerebral seizure focus	In-Patient Attendance & Other Medical Services
8707	Inpatient EEG; monitoring for localisation of cerebral seizure focus with a minimum of 4 hour video recording	In-Patient Attendance & Other Medical Services
8710	Evoked potentials	In-Patient Attendance & Other Medical Services
8715	Full Lung function including diffusion tests	In-Patient Attendance & Other Medical Services
8720	Oesophageal manometry	In-Patient Attendance & Other Medical Services
8725	pH Probe	In-Patient Attendance & Other Medical Services
10000	Medical Management For Specific Paediatric Medical Day Care Procedures/Investigations	In-Patient Attendance & Other Medical Services
10010	Emergency Overnight Medical Admission for Neonates or medical care	Neonatology
10017	Neonatal Intensive Care - Inpatient Attendance Benefit 1 day stay	Neonatology
10018	Neonatal Intensive Care - Inpatient Attendance Benefit 2 day stay	Neonatology
10019	Neonatal Intensive Care - Inpatient Attendance Benefit 3 day stay	Neonatology
10020	Neonatal Intensive Care - Inpatient Attendance Benefit 4 day stay	Neonatology
10021	Neonatal Intensive Care - Inpatient Attendance Benefit 5 day stay	Neonatology
10022	Neonatal Intensive Care - Inpatient Attendance Benefit 6 day stay	Neonatology
10023	Neonatal Intensive Care - Inpatient Attendance Benefit 7 day stay	Neonatology
10024	Neonatal Intensive Care - Inpatient Attendance Benefit 8 day stay	Neonatology
10025	Neonatal Intensive Care - Inpatient Attendance Benefit 9 day stay	Neonatology
10026	Neonatal Intensive Care - Inpatient Attendance Benefit 10 day stay	Neonatology
10027	Neonatal Intensive Care - Inpatient Attendance Benefit 11 day stay	Neonatology
10028	Neonatal Intensive Care - Inpatient Attendance Benefit 12 day stay	Neonatology
10029	Neonatal Intensive Care - Inpatient Attendance Benefit 13 day stay	Neonatology

Code	Description	Speciality
10030	Neonatal Intensive Care - Inpatient Attendance Benefit 14 day stay	Neonatology
10031	Neonatal Intensive Care - Inpatient Attendance Benefit 15 day stay	Neonatology
10032	NEONATAL INTENSIVE CARE ordinary inpatient consultation	Neonatology
10033	NEONATAL INTENSIVE CARE major inpatient consultation	Neonatology
10034	Anaesthesia - ICU Inpatient Medicine Benefit 1 day stay	In-Patient Attendance & Other Medical Services
10035	Anaesthesia - ICU Inpatient Medicine Benefit 2 day stay	In-Patient Attendance & Other Medical Services
10036	Anaesthesia - ICU Inpatient Medicine Benefit 3 day stay	In-Patient Attendance & Other Medical Services
10037	Anaesthesia - ICU Inpatient Medicine Benefit 4 day stay	In-Patient Attendance & Other Medical Services
10038	Anaesthesia - ICU Inpatient Medicine Benefit 5 day stay	In-Patient Attendance & Other Medical Services
10039	Anaesthesia - ICU Inpatient Medicine Benefit 6 day stay	In-Patient Attendance & Other Medical Services
10040	Anaesthesia - ICU Inpatient Medicine Benefit 7 day stay	In-Patient Attendance & Other Medical Services
10041	Anaesthesia - ICU Inpatient Medicine Benefit 8 day stay	In-Patient Attendance & Other Medical Services
10042	Anaesthesia - ICU Inpatient Medicine Benefit 9 day stay	In-Patient Attendance & Other Medical Services
10043	Anaesthesia - ICU Inpatient Medicine Benefit 10 day stay	In-Patient Attendance & Other Medical Services
10044	Anaesthesia - ICU Inpatient Medicine Benefit 11 day stay	In-Patient Attendance & Other Medical Services
10045	Anaesthesia - ICU Inpatient Medicine Benefit 12 day stay	In-Patient Attendance & Other Medical Services
10046	Anaesthesia - ICU Inpatient Medicine Benefit 13 day stay	In-Patient Attendance & Other Medical Services
10047	Anaesthesia - ICU Inpatient Medicine Benefit 14 day stay	In-Patient Attendance & Other Medical Services
10048	Anaesthesia - ICU Inpatient Medicine Benefit 15 day stay	In-Patient Attendance & Other Medical Services
10049	Inpatient Medical Service attendance 1 day stay	In-Patient Attendance & Other Medical Services

Code	Description	Speciality
10050	Inpatient Medical Service attendance 2 day stay	In-Patient Attendance & Other Medical Services
10051	Inpatient Medical Service attendance 3 day stay	In-Patient Attendance & Other Medical Services
10052	Inpatient Medical Service attendance 4 day stay	In-Patient Attendance & Other Medical Services
10053	Inpatient Medical Service attendance 5 day stay	In-Patient Attendance & Other Medical Services
10054	Inpatient Medical Service attendance 6 day stay	In-Patient Attendance & Other Medical Services
10055	Inpatient Medical Service attendance 7 day stay	In-Patient Attendance & Other Medical Services
10056	Inpatient Medical Service attendance 8 day stay	In-Patient Attendance & Other Medical Services
10057	Inpatient Medical Service attendance 9 day stay	In-Patient Attendance & Other Medical Services
10058	Inpatient Medical Service attendance 10 day stay	In-Patient Attendance & Other Medical Services
10059	Inpatient Medical Service attendance 11 day stay	In-Patient Attendance & Other Medical Services
10060	Inpatient Medical Service attendance 12 day stay	In-Patient Attendance & Other Medical Services
10061	Inpatient Medical Service attendance 13 day stay	In-Patient Attendance & Other Medical Services
10062	Inpatient Medical Service attendance 14 day stay	In-Patient Attendance & Other Medical Services
10063	Inpatient Medical Service attendance 15 day stay	In-Patient Attendance & Other Medical Services
10064	Inpatient Major Medical Illnesses	In-Patient Attendance & Other Medical Services
10066	An ordinary inpatient consultation	In-Patient Attendance & Other Medical Services
10067	A major inpatient consultation	In-Patient Attendance & Other Medical Services
10068	A major inpatient psychiatric consultation	In-Patient Attendance & Other Medical Services

Code	Description	Speciality
10069	Anaesthesia - ICU Inpatient Medicine Benefit per day after day 15 of stay	In-Patient Attendance & Other Medical Services
10070	Inpatient Medical Service attendance per day after day 15 of stay	In-Patient Attendance & Other Medical Services
10071	Inpatient Neonatology Intensive Care attendance per day after day 15 of stay	In-Patient Attendance & Other Medical Services
10072	A major inpatient palliative medicine consultation	Palliative Medicine
10081	Paediatricintensive Care - Inpatient Attendance Benefit 1 day stay	Neonatology
10081	Paediatricintensive Care - Inpatient Attendance Benefit 1 day stay	Neonatology
10082	Paediatricintensive Care - Inpatient Attendance Benefit 2 day stay	Neonatology
10082	Paediatricintensive Care - Inpatient Attendance Benefit 2 day stay	Neonatology
10083	Paediatricintensive Care - Inpatient Attendance Benefit 3 day stay	Neonatology
10083	Paediatricintensive Care - Inpatient Attendance Benefit 3 day stay	Neonatology
10084	Paediatricintensive Care - Inpatient Attendance Benefit 4 day stay	Neonatology
10084	Paediatricintensive Care - Inpatient Attendance Benefit 4 day stay	Neonatology
10085	Paediatricintensive Care - Inpatient Attendance Benefit 5 day stay	Neonatology
10085	Paediatricintensive Care - Inpatient Attendance Benefit 5 day stay	Neonatology
10086	Paediatricintensive Care - Inpatient Attendance Benefit 6 day stay	Neonatology
10086	Paediatricintensive Care - Inpatient Attendance Benefit 6 day stay	Neonatology
10087	Paediatricintensive Care - Inpatient Attendance Benefit 7 day stay	Neonatology
10087	Paediatricintensive Care - Inpatient Attendance Benefit 7 day stay	Neonatology
10088	Paediatricintensive Care - Inpatient Attendance Benefit 8 day stay	Neonatology
10088	Paediatricintensive Care - Inpatient Attendance Benefit 8 day stay	Neonatology
10089	Paediatricintensive Care - Inpatient Attendance Benefit 9 day stay	Neonatology
10089	Paediatricintensive Care - Inpatient Attendance Benefit 9 day stay	Neonatology
10090	Paediatricintensive Care - Inpatient Attendance Benefit 10 day stay	Neonatology
10090	Paediatricintensive Care - Inpatient Attendance Benefit 10 day stay	Neonatology
10091	Paediatricintensive Care - Inpatient Attendance Benefit 11 day stay	Neonatology
10091	Paediatricintensive Care - Inpatient Attendance Benefit 11 day stay	Neonatology

Code	Description	Speciality
10092	Paediatricintensive Care - Inpatient Attendance Benefit 12 day stay	Neonatology
10092	Paediatricintensive Care - Inpatient Attendance Benefit 12 day stay	Neonatology
10093	Paediatricintensive Care - Inpatient Attendance Benefit 13 day stay	Neonatology
10093	Paediatricintensive Care - Inpatient Attendance Benefit 13 day stay	Neonatology
10094	Paediatricintensive Care - Inpatient Attendance Benefit 14 day stay	Neonatology
10094	Paediatricintensive Care - Inpatient Attendance Benefit 14 day stay	Neonatology
10095	Paediatricintensive Care - Inpatient Attendance Benefit 15 day stay	Neonatology
10095	Paediatricintensive Care - Inpatient Attendance Benefit 15 day stay	Neonatology
10096	Paediatricintensive Care - Inpatient Attendance Benefit - Each day after Day 15	Neonatology
10096	Paediatricintensive Care - Inpatient Attendance Benefit - Each day after Day 15	Neonatology

MINOR PROCEDURES CODES & RATES

Code	Description	Indicators
405	Destruction of lesion(s) by any method, genital/anal warts (e.g. condyloma, papilloma, molluscum contagiosum, herpetic vesicle); per session (I.P.)	I.P., Side Room, Service
525	Ischio rectal abscess, incision and drainage (I.P.)	I.P., Service
1505	Abscess, cyst or tumour, aspiration of (I.P.)	I.P., Side Room, Service
1509	Biopsy of skin, subcutaneous tissue and/or mucous membrane including simple closure (I.P.)	I.P., Side Room, Service
1516	Destruction by cryotherapy of actinic keratosis or warts other than plantar warts with or without surgical curettement, one lesion (I.P.) NOTE: Repeat visits for lesion removal will not be paid at the "one lesion" rate. A claim should only be made at the end of a course of treatment.	I.P., Side Room, Service
1517	Destruction by cryosurgery of actinic keratoses or warts other than plantar warts with or without surgical curettement, two to fourteen lesions (I.P.)	I.P., Side Room, Service
1522	Destruction by any method, including laser, with or without surgical curettement, all benign except port wine stains or premalignant facial lesions, including local anaesthesia, patient examination, evaluation and assessment, one lesion (I.P.)	I.P., Side Room, Service
1523	Destruction by any method, including laser, with or without surgical curettement, all benign (except port wine stains) or premalignant facial lesions, including local anaesthesia, patient examination, evaluation and assessment, up to five lesions (I.P.)	I.P., Side Room, Service
1524	Destruction by any method, including laser, with or without surgical curettement, all benign (except port wine staines) or premalignant facial lesions, including local anaesthesia, patient examination, evaluation and assessment, greater than five lesions (I.P.)	I.P., Side Room, Service
1525	Foreign body, removal of	Side Room, Service
1540	Skin abscess, (superficial) incision and drainage of (I.P.)	I.P., Side Room, Service
1546	Enucleation of lipoma	I.P., Daycare, Service
1552	Surgical excision of benign lesion or lesions (includes sebaceous cysts) (I.P.)	I.P., Side Room, Service, Histology to a limit of €65
1554	Surgical excision of benign lesion or lesions of face (includes sebaceous cysts) (I.P.)	I.P., Side Room, Service, Histology to a limit of €65

1601	Wounds up to 2.5cm in total length, suture of with one layer repair of the epidermis, dermis or subcutaneous tissues with suture NOTE: For procedure code 1601, 1602, 1603, benefit includes wound closure by tissue adhesives' (e.g. Two-cyanocrylate) 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 uner our out-patient products.	, Side Room
1602	Wounds from 2.6cm to 7.5cm in total length, suture of with one layer repair of the epidermis, dermis or subcutaneous tissues with suture NOTE: For procedure code 1601, 1602, 1603, benefit includes wound closure by tissue adhesives' (e.g. Two-cyanocrylate) 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 uner our out-patient products.	Side Room
1615	Wounds and sinuses, debridement, curettage of	Side Room, Service
1620	Wound(s) repair, complete requiring in addition to layer closure, debridement and repair of complicated lacerations or avulsions, extensive undermining, stents or retention sutures, with or without creation of the defect and necessary preparation for repairs or debridement and repair of complicated lacerations or avulsions	Service
1641	Therapeutic phlebotomy for patients with polycythemia rubre vera or haemachromatosis, by the consultant physician.	Side Room
1800	Epistaxis, anterior packing and/or cautery (I.P.)	I.P., Side Room, Service
2505	Foreign body, removal of, from conjunctiva	Side Room, Service
2520	Wounds, repair	
3120	Nail, removal of	Side Room, Service, Histology to a limit of €65
3155	Whitlow, incision and drainage	Side Room, Service
4155	Avulsion of nail plate, partial or complete, simple	Side Room, Service
4160	Excision of nail and nail matrix, partial or complete (e.g. ingrown or deformed nail), for permanent removal	Side Room, Service
4210	Plantar warts, surgical excision, one or more (not local application, cryotherapy etc.)	Daycare, Service
4211	Plantar warts, one or more, local application, per complete course of therapy	Side Room, Service
4332	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g. fingers, toes) (I.P.)	I.P., Side Room, Service
4333	Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (e.g. temporomandibular acromioclavicular, wrist, elbow or ankle, olecranon bursa) (I.P.)	I.P., Side Room, Service
4334	Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g. shoulder, hip, knee joint, subacromial bursa) (I.P.)	I.P., Side Room, Service
49371	Excision of benign or malignant lesion(s), any area; adjacent tissue transfers or rearrangement, 4 sq. cm or less	Side Room Only

Notes

Consultant Non Hospital	This fee is payable where NO hospital bill is received other than from approved treatment centres
Review	A review of services and rates in on-going in this area with expected changes (if any) to be introduced form 01 January 2013

PATHOLOGY CODES & RATES

Code	Description	Speciality	Pathology Category
8899	Tests as Listed for Day Case patients where clinically required and not as a screening tool for "not at risk patients". This code will not apply for testing in respect of members attending for day case Chemotherapy (codes 1608,1609 and 1619), where code 8900 will apply	Pathology	Category 1 (One Or More Investigations Per Admission)
8900	Tests as Listed (Inpatient only), where clinically required and not as a screening tool for "not at risk patients"	Pathology	Category 1 (One Or More Investigations Per Admission)
8904	FBC + manual film ± eosinophil count for neonates	Pathology	Category 3 (Per Investigation)
8915	LAP	Pathology	Category 3 (Per Investigation)
8925	HbA2	Pathology	Category 4 (Per Investigation)
8940	U. haemosiderin	Pathology	Category 4 (Per Investigation)
8970	MSU + culture	Pathology	Category 3 (Per Investigation)
9030	Sweat investigation	Pathology	Category 3 (Per Investigation)
9035	Reticulocyte count	Pathology	Category 3 (Per Investigation)
9036	RBC Osmotic fragility & autohaemolysis	Pathology	Category 3 (Per Investigation)
9040	Kliehauer	Pathology	Category 3 (Per Investigation)
9045	Stool O+P	Pathology	Category 3 (Per Investigation)
9050	IF - single antibody e.g. ANF (not claimable if this leads to typing in Categories 4 or 5)	Pathology	Category 3 (Per Investigation)
9059	Catecholamines and porphyrins - once per claim only	Pathology	Category 3 (Per Investigation)
9060	Cholinesterase/pseudocholinesterase - once per claim only	Pathology	Category 3 (Per Investigation)

Code	Description	Speciality	Pathology Category
9061	Carnites Acyl - Total and free carnetines	Pathology	Category 3 (Per Investigation)
9100	Interpretive review of culture result, bacterial, any source, by Consultant Microbiologist or Clinical Pathologist, with isolates where inicated with or without definitive identification of isolates to the genus or species level incluing any other tests	Pathology	Category 3 (Per Investigation)
9101	MRSA or other antimicrobial resistant organism, interpretive review of culture from all screening swabs from the patient, for "at risk patients" only as defined by the SARI Infection Control Subcommittee and not for routine screening	Pathology	Category 3 (Per Investigation)
9160	Electrophoresis and chromatographic procedures (serum, lipoprotein, urine)	Pathology	Category 3 (Per Investigation)
9161	Gas Chromatographic/Mass Spectrometer for organic acid(s), assay.	Pathology	Category 3 (Per Investigation)
9175	CSF including oligoclonal bands	Pathology	Category 4 (Per Investigation)
9180	Myeloma Screen including electrophoresis	Pathology	Category 4 (Per Investigation)
9181	Trace metals	Pathology	Category 4 (Per Investigation)
9182	Vits A, D & E	Pathology	Category 4 (Per Investigation)
9200	Bleeding time	Pathology	Category 4 (Per Investigation)
9202	Antibiotic assay - maximum payable, four per claim	Pathology	Category 4 (Per Investigation) - Maximum Of 4 Per Claim
9203	MBC	Pathology	Category 4 (Per Investigation)
9204	MIC	Pathology	Category 4 (Per Investigation)
9205	Ab identification (transfusion)	Pathology	Category 4 (Per Investigation)
9206	Cidal levels	Pathology	Category 4 (Per Investigation)
9207	Toxin levels (e.g. clostridium difficle/ botulinium). Exact toxin being investigated must be specified	Pathology	Category 4 (Per Investigation)
9210	Hb electrophoresis	Pathology	Category 4 (Per Investigation)

Code	Description	Speciality	Pathology Category
9223	HIV, VD or Hepatitis screen	Pathology	Category 4 (Per Investigation)
9224	Teicoic acid, CH100 - functional assay	Pathology	Category 4 (Per Investigation)
9226	Thrombophilia screen - this consists of three or more of the following items: Antithrombin 3, protein C, protein S, factor 7, factor 12, platelet aggregation (spontaneous, second wave of aggregation with weak ADP, and response to dilutions of epinephrine)	Pathology	Category 4 (Per Investigation)
9227	CH50 - functional assay	Pathology	Category 4 (Per Investigation)
9270	Paraprotein typing	Pathology	Category 5 (Per Investigation)
9280	Gel electrophoresis	Pathology	Category 4 (Per Investigation)
9301	Diabetic KA/hyperosmolar coma	Pathology	Category 5 (A) Once Per Claim
9302	Acute Renal failure	Pathology	Category 5 (A) Once Per Claim
9303	Acute hepatic failure	Pathology	Category 5 (A) Once Per Claim
9304	Dynamic endocrine function tests (IST, Synact, TRH, Dex supp)	Pathology	Category 5 (A) Once Per Claim
9306	Porphyria investigation	Pathology	Category 5 (A) Once Per Claim
9307	Full endocrinological investigation of infertility	Pathology	Category 5 (A) Once Per Claim
9308	Diabetes insipidus / or SIADH including ADH measurements	Pathology	Category 5 (A) Once Per Claim
9309	Full investigations for inborn errors of metabolism in paediatric patients	Pathology	Category 5 (A) Once Per Claim
9312	Hypoglycaemia - full biochemical investigation of;	Pathology	Category 5 (A) Once Per Claim
9313	Acyl Carnitine	Pathology	Category 5 (A) Once Per Claim
9359	Full investigations for inborn errors of metabolism in paediatric patients (not including examinations emanating from the National Newborn Screening Programme for Inherited Metabolic and Genetic Disorders) (9359 is not claimable with 9309)	Pathology	Category 5 (Per Investigation)

Code	Description	Speciality	Pathology Category
9360	Small (1-2 blocks) include cytology and neuropathology	Pathology	Category 5 (Per Investigation)
9381	Interpretive review of culture of CSF, blood by a Consultant Microbiologist or a Clinical Pathologist	Pathology	Category 5 (Per Investigation)
9385	Interpretive review of viral, bacterial or fungal serology or viral culture by Consultant Microbiologist or Clinical Pathologist	Pathology	Category 4 (Per Investigation)
9391	Antisperm antibodies	Pathology	Category 5 (Per Investigation)
9392	IF - autoantibody screen and/or DNA Abs and/or subtyping	Pathology	Category 5 (Per Investigation)
9393	Polymerase chain reaction	Pathology	Category 5 (Per Investigation)
9501	Marrow aspirate (not immunocyto- see Category 8)	Pathology	Category 6 (Per Investigation)
9502	Marrow trephine (see Cat 7 if trephine and aspirate done together)	Pathology	Category 6 (Per Investigation)
9503	HLA typing	Pathology	Category 6 (Per Investigation)
9504	Immunofluorescence	Pathology	Category 6 (Per Investigation)
9505	Immunocytochemistry	Pathology	Category 8
9506	Electron microscopy	Pathology	Category 6 (Per Investigation)
9507	Flow cytometry for CD4, CD8 and CD34 counts	Pathology	Category 4 (Per Investigation)
9508	Peripheral blood stem harvesting examination	Pathology	Category 6 (Per Investigation)
9530	Medium (e.g. description + 3-5 blocks)	Pathology	Category 6 (Per Investigation)
9531	Cell Block and smear examination from Fine Needle Aspiration biopsy	Pathology	Category 6 (Per Investigation)
9535	Lymph node	Pathology	Category 6 (Per Investigation)
9539	Upper G.I. Series	Pathology	Category 6 (Per Investigation)
9540	Colonoscopic series	Pathology	Category 6 (Per Investigation)

Code	Description	Speciality	Pathology Category
9541	Prostate series	Pathology	Category 6 (Per Investigation)
9545	Parathyroid	Pathology	Category 6 (Per Investigation)
9550	Clinical (i.e. non screening) cytology (not including smear + section, see Cat 7)	Pathology	Category 6 (Per Investigation)
9601	Liver, renal biopsies including special stains	Pathology	Category 7 (Per Investigation)
9603	Marrow aspirate and trephine done together (i.e. by same Pathologist)	Pathology	Category 7 (Per Investigation)
9604	Platelet Aggregation Studies	Pathology	Category 7 (Per Investigation)
9605	Immune complex assays, not otherwise listed in Category 1	Pathology	Category 5 (Per Investigation)
9606	Multimer analysis for Von Willebrand disease	Pathology	Category 7 (Per Investigation)
9610	WBC function tests	Pathology	Category 7 (Per Investigation)
9650	Large (5 + blocks and all major dissections)	Pathology	Category 7 (Per Investigation)
9670	IF - frozen section direct or indirect	Pathology	Category 7 (Per Investigation)
9691	Immunoh+istology (include fluorescence & in-situ hybridisation)	Pathology	Category 8 (Only Once Per Request)
9693	Frozen section or rapid intraoperative diagnosis	Pathology	Category 8 (Only Once Per Request)
9694	Gene rearrangement studies	Pathology	Category 4 (Per Investigation)
9695	Tumour aneuploidy by flow cytometry	Pathology	Category 8
9696	Gene re-arrangement studies for the diagnosis of leukaemia or lymphoma (includes molecular isolation or extraction; enzymatic separation and nuclei acid probes)	Pathology	Category 8
9700	All tests associated with Obstetrics, including normal delivery, caesarean section and miscarriage	Pathology	Category 9 (Once Per Claim)
8691	Consultant Pathologist In-Patient Consultation (refer to specific rule, with special reference and applicability to tertiary level hospital review only)	Pathology	

Codes 8899 and 8900, includes all codes not listed in the Schedule of Benefits and specifically:

Haematology	APTT, PT & INR
	Blood Group & uncomplicated Xmatch
	Coagulation Factor Assay
	Cold Aggluts
	FBC no film
	FBC & manual film +- eosinophil count
	Ferritin
	Fibrinogen
	HbH
	in/direct Coombs's test
	Iron
	Mononspot
	RBC autohaemolysisi
	RBC osm frag.
	Platelet Agg.
	Serum Folate
	Red Cell Folate

Biochemistry	All nuclear medicine in-vitro investigations (except Category 5)
	Profile - Renal - 1 or more
	Profile - Hepatic - 1 or more
	Profile - Cardiac - 1 or more
	Profile - Thyroid - 1 or more
	Profile -Bone (not PTH) - 1 or more
	Profile - Lipid - 1 or more
	Biochemistry of hypertension
	Drug levels including RIA)
	GTT
	HbAIC
	HPLC
	Single analytes
	Tumour markers

Immunology	ά-1-AT
	Allergens
	C3
	C4
	Caeruloplasmin
	CRP
	Cryoglobulins
	IgE
	Igs
	PFB
	Rλ Screen
	Streptolysin
	Thyroid Abs
	Transferrin

Endocrinology	Hormone Levels

Microbiology	Pregnancy test
	MRSA or other antimicrobial resistant organism, interpretive review of culture from all screening swabs from the patient. (Unless for at Risk patients as defined by Aviva Health)
	Stool O/B
	All other cultures not listed

Definition of "at risk patient" for MRSA testing:

- Previously known as being MRSA positive
- Transfers from a hospital or medical institution that is not MRSA free
- high risk patients for cardiac surgery, implantation surgery
- Deep Body cavity surgery
- members suffering from wounds or ulcers
- Intensive Care Unit admission

PATHOLOGIST SERVICES

1. The benefit payable covers:

    - Performance or personal supervision of the investigation/s
    - Evaluation of the results of the investigation/s
    - Written report and/or discussion with the referring doctor

2. For the period of this agreement, benefit for the procedures listed under codes 8899 / 8900 are a general fee intended to recognise the managerial, quality control and global interpretative input of all Consultant Pathologists within a multi-disciplinary group into the clinical laboratory management of a patient. The inclusion of a schedule of largely automated analyses in the category is a non-volume related indicator of the above activities carried out by Consultant Pathologist and is not intended to specifically reflect the input of individual sub-specialities in which most of these investigations are carried out. Aviva will recognise only one such charge for code 8900 for a patients' episode of care which requires the use of consultant pathologist services but will not pay this fee where any charges for this service benefit (code 8900) are raised by any other Consultant Pathologist or Consultant Pathologist group during the same episode of care.

3. Where a Specialist Clinical Pathologist admits a patient and provides continuing care, the In-Patient Attendance benefit is payable.

4. The benefits towards pathology investigations are payable in respect of Consultant Pathologists' services only.

5. The code of the precise investigations(s) carried out must be reported to Aviva Health in order that benefit may be paid.

6. Pathology investigations performed on an out-patient basis, may only be included in an out-patient claim.

7. Pathology investigations performed as part of a Day Care case may be included in the Day Care claim.

8. For hospitals which operate through the Aviva direct settlement of hospital and associated consultant professional fee charges, the claiming of pathology benefit will continue on the basis of a fully completed and collated Aviva claim form as completed by the admitting consultant surgeon/physician, which will be submitted by the hospital in conjunction with its own invoice for services provided. However, in **exceptional circumstances** when unforeseen delays occur in the submission of a claim in excess of three months from the date of test/service due to extenuating circumstances,the Consultant Pathologist may submit to Aviva Health, a completed claim form which must include side 1 of the form completed and signed by the Aviva member, side 2 of the claim form completed in as far as is possible by an attending Consultant, to comprise clinical

data including member Discharge Summary (where available),and all other invoices related to the admission are attached to the claim i.e. Hospital and other Secondary Consultants. This exception may not be availed of, for routine bill submission due to routine or on-going completion delays by either the submitting hospital or the admitting consultant. For a specific Consultant (or Consultant Group) to avail of this facility they must notify the Claims Manager of Aviva Health explaining the reason for the use of this exception to ensure that issues arising from the use of this exemption are maintained at a minimal level.

9. Benefit is not payable for samples sent to an external laboratory, because the external laboratory results are inclusive of Consultant Pathologist interpretation of the test(s).

10. Pathology investigations not specifically listed in the pathology section of the schedule of benefits will be deemed to be listed under code 8900.

11. An in-patient consultation is payable to a Consultant Pathologist where the patient is transferred from one hospital to another for **tertiary level care** arising from complicated illness e.g. oncology, neurosurgery, serious trauma etc. It involves an evaluation of the results of the original pathology tests in association with any additional clinical work up necessary in the second hospital including the provision of a written report from the Consultant Pathologist. (Additional pathology tests performed in the second hospital may be claimed separately).

Code	Description
8691	Consultant Pathologist In-Patient Consultation (refer to specific rule, with special reference and applicability to tertiary level hospital review only)

NOTES

8899	Tests as Listed for Day Case patients where clinically required and not as a screening tool for "not at risk patients". This code will not apply for testing in respect of members attending for day case Chemotherapy (codes 1608,1609and 16i9), where code 8900 will apply
8900	Tests as Listed (Inpatient only), where clinically required and not as a screening tool for "not at risk patients"
8904	FBC + manual film ± eosinophil count

This is only payable for approved neonatal intensive care units only, and is payable for 1 test per week in stable babies. For pre term babies of less than 1.5 Kg., a maximum of 10 tests are payable.

9050	IF - single antibody e.g. ANF (not claimable if this leads to typing in Categories 4 or 5)

This is not payable with Code 9392

9101	MRSA or other antimicrobial resistant organism, interpretive review of culture from all screening swabs from the patient, for "at risk patients" only as defined by the SARI Infection Control Subcommittee and not for routine screening

Definition of "at risk patient" for MRSA testing:

- Previously known as being MRSA positive
- Transfers from a hospital or medical institution that is not MRSA free
- high risk patients for cardiac surgery, implantation surgery
- Deep Body cavity surgery
- members suffering from wounds or ulcers
- Intensive Care Unit admission

9205	Ab identification (transfusion) (one or more antibodies)

This is only payable where:
An antibody has been identified as part of the group and uncomplicated cross match incorporated into code 8900 and / or there is a high clinical suspicion that an antibody of rare clinical significance is present.

9226	Thrombophilia screen

This consists of three or more of the following items: Antithrombin 3, protein C, protein S, factor 7, factor 12, platelet aggregation (spontaneous, second wave of aggregation with weak ADP, and response to dilutions of epinephrine)

9100	Interpretive review of culture result, bacterial, any source, by Consultant Microbiologist or Clinical Pathologist, with isolates where indicated with or without definitive identification of isolates to the genus or species level including any other tests

9301	Diabetic KA/hyperosmolar coma
9302	Acute Renal failure
9303	Acute hepatic failure
9306	Porphyria investigation
9308	Diabetes insipidus / or SIADH including ADH measurements
9312	Hypoglycaemia – full biochemical investigation of;

These codes are only claimable once per claim and are claimable only for the test when the results are outside normal or expected ranges of result for the patient's condition. For clarity Aviva will only pay per disease / condition investigation – thus usually only one payment will arise – unless multiple pathologies are investigated.

9309	Full investigation for inborn errors of metabolism in paediatric patients

Not claimable with 9359

9312	Hypoglycaemia – full biochemical investigation of;

The investigation must include a combination of some of the following:

- Insulin & C-peptide
- Keynotes
- Beta-hydroxbutyrate and acetoacetate
- Non-esterified fatty acids

- Lactate and Pyruvate
- Cortisol and growth hormone

9359	Full investigations for inborn errors of metabolism in paediatric patients

Code 9359 is not claimable with 9309.
Code 9359 will not include examinations emanating from the National Newborn Screening Programme for Inherited Metabolic and Genetic Disorders

9360	Small (1-2 blocks) include cytology and neuropathology

When 2 or more tissue sources from separate sites require examination they must be assigned one code only reflective of the number of clocks it is necessary to examine the separate sites must be identified on the claim form.

Skin lesion(s) are payable based on the total; number of blocks it is necessary to examine and only one of code, 9360, 9530 or 9650 is payable

9530	Surgical Pathology, gross microscopic examination, medium. requiring examination of between 3 and 5 blocks

When 2 or more tissue sources from separate sites require examination they must be assigned one code only reflective of the number of clocks it is necessary to examine the separate sites must be identified on the claim form.

Skin lesion(s) are payable based on the total; number of blocks it is necessary to examine and only one of code, 9360, 9530 or 9650 is payable

9650	Large (5 + blocks and all major dissections)

A total of only 5+ blocks from a specific site is payable under this code.

8899	Tests as Listed for Day Case patients where clinically required and not as a screening tool for "not at risk patients". This code will not apply for testing in respect of members attending for day case Chemotherapy (codes 1608 and 16i9), where code 8900 will apply
8900	Tests as Listed (Inpatient only), where clinically required and not as a screening tool for "not at risk patients"

Codes 8899 and 8900, includes all codes not listed in the Schedule of Benefits and specifically:

Haematology	APTT, PT & INR
	Blood Group & uncomplicated Xmatch
	Coagulation Factor Assay
	Cold Aggluts
	FBC no film
	FBC & manual film +- eosinophil count
	Ferritin
	Fibrinogen
	HbH
	in/direct Coombs's test
	Iron
	Mononspot
	RBC autohaemolysisi
	RBC osm frag.
	Platelet Agg.
	Serum Folate
	Red Cell Folate

Biochemistry	all nuclear medicine in-vitro investigations (except Category 5)
	Profile - Renal - 1 or more
	Profile - Hepatic - 1 or more
	Profile - Cardiac - 1 or more
	Profile - Thyroid - 1 or more
	Profile - Bone (not PTH) - 1 or more
	Profile - Lipid - 1 or more
	Biochemistry of hypertension
	Drug levels including RIA)
	GTT
	HbAIC
	HPLC
	Single analytes
	Tumour markers

Immunology	ά-1-AT
	Allergens
	C3
	C4
	Caeruloplasmin
	CRP
	Cryoglobulins
	IgE
	Igs
	PFB
	Rλ Screen
	Streptolysin
	Thyroid Abs
	Transferrin

Endocrinology	Hormone Levels

Microbiology	Pregnancy test
	MRSA or other antimicrobial resistant organism, interpretive review of culture from all screening swabs from the patient. (Unless for at Risk patients as defined by Aviva Health)
	Stool O/B
	All other cultures not listed

9181	Trace metals

This is payable only once per claim and includes:

aluminium	-	blood
aluminium	-	urine/ dialysate
antimony	-	blood
antimony	-	urine
arsenic	-	hair
arsenic	-	urine
arsenic	-	urine - speciated
bismuth		
boron		
bromide		
cadmium	-	blood
cadmium	-	urine
chromium	-	blood
chromium	-	urine
copper	-	blood
copper	-	urine
lead	-	blood
lead	-	urine
manganese	-	blood
manganese	-	urine
molybdenum		
nickel		
platinum		
selenium	-	blood
selenium	-	urine
strontium		
thallium	-	blood
thallium	-	urine
tin		
zinc	-	plasma
zinc	-	urine

12. Explanation of Categories

Category Codes Title Plain English Rules

1 8899, 8900
ONE OR MORE INVESTIGATIONS PER ADMISSION IS COVERED
We will only pay once per episode of admission irrespective of quantity of these tests performed

3 8904, 8915, 9035, 9036, 9040
PER INVESTIGATION
Aviva will only pay per disease / condition investigation – thus usually only one payment will arise – unless multiple pathologies are investigated Only where relevant test are reviewed AND reported upon by the relevant Consultant Haematologist/ Clinical Pathologist

3 8970, 9045, 9100, 9101, 9202, 9203, 9204, 9206, 9207, 9223, 9385
PER INVESTIGATION
Aviva will only pay per disease / condition investigation – thus usually only one payment will arise – unless multiple pathologies are investigated Only where relevant test are reviewed AND reported upon by the relevant Consultant Microbiologist/ Clinical Pathologist

3 9030, 9050, 9059, 9060, 9061
PER INVESTIGATION
Aviva will only pay per disease / condition investigation – thus usually only one payment will arise – unless multiple pathologies are investigated

4 8925, 8940, 9160, 9175, 9181, 9180, 9182, 9200, 9205, 9210, 9224, 9226, 9227, 9280, 9694, 9507
PER INVESTIGATION
Aviva will only pay per disease / condition investigation – thus usually only one payment will arise – unless multiple pathologies are investigated

5(A) 9301, 9302, 9303, 9300
ONCE PER CLAIM
Only where relevant test are reviewed AND reported upon by the relevant Consultant Biochemist/ Clinical Pathologist

5 9270, 9539, 9360, 9381, 9391, 9392, 9393, 9605
PER INVESTIGATION
Aviva will only pay per disease / condition investigation – thus usually only one payment will arise – unless multiple pathologies are investigated

6 9501, 9502, 9503, 9504, 9506, 9508, 9530, 9531, 9535, 9539, 9540, 9541, 9545, 9550
PER INVESTIGATION

Aviva will only pay per disease / condition investigation – thus usually only one payment will arise – unless multiple pathologies are investigated

7 9601, 9603, 9604, 9606, 9610, 9650, 9670
PER INVESTIGATION
Aviva will only pay per disease / condition investigation – thus usually only one payment will arise – unless multiple pathologies are investigated

8 9691,9691, 9695, 9696
ONCE PER REQUEST
This will only paid once for each request made

9 9700
ONCE PER CLAIM

RADIOLOGY CODES & RATES

Code	Description	Speciality
1197	Preoperative placement of needle localisation wire, breast, one or more lesions (Benefit is payable in addition to the surgery, at a separate operative session, for lesion(s) removalBenefit is payable in addition to the surgery, at a separate operative session, for lesion(s) removal)	Radiology Breast
6000	Plain film, abdomen	Radiology
6001	Plain film abdomen complete, including decubitus and/or erect views	Radiology
6005	Barium enema	Radiology
6010	Barium enema, double contrast.	Radiology
6011	Barium enema, therapeutic for reduction of intussusception	Radiology
6015	Barium meal	Radiology
6020	Barium meal and follow through or small bowel study	Radiology
6030	Barium swallow and meal	Radiology
6035	Cholecystogram	Radiology
6040	Screening crosbie capsule	Radiology
6045	Screening diaphragm	Radiology
6055	IV cholangiogram	Radiology
6066	Defaecating proctogram	Radiology
6070	T - tube cholangiogram	Radiology
6078	Chest, PA, lateral and apical including ribs	Radiology
6090	Larynx	Radiology
6095	Sternum and chest	Radiology
6100	Thoracic inlet	Radiology
6115	Ankle	Radiology
6119	Ankle, complete, minimum of three views including inversion/eversion	Radiology
6120	Bone age	Radiology
6121	Acromioclavicular joints, bilateral, with or without weight distraction	Radiology
6122	Knee, complete, including oblique(s), and tunnel, and/or patellar and/or standing views	Radiology

Code	Description	Speciality
6125	Calcaneum	Radiology
6130	Clavicle	Radiology
6135	Elbow	Radiology
6140	Femur	Radiology
6145	Finger/toe	Radiology
6150	Foot	Radiology
6155	Hand	Radiology
6165	Humerus	Radiology
6170	Knee	Radiology
6175	Limb length/orthopaedic measurement	Radiology
6180	Pelvis (inc. hips)	Radiology
6185	Radius and ulna	Radiology
6190	Sacro-iliac joints	Radiology
6195	Scaphoid	Radiology
6200	Scapula	Radiology
6205	Scoliosis series	Radiology
6210	Shoulder	Radiology
6215	Sternoclavicular joint	Radiology
6220	Tibia and fibula	Radiology
6225	Wrist	Radiology
6235	Abdominal scan (Meckel's)	Radiology
6240	White blood cell scan (WBC)	Radiology
6255	Cholesterol scan	Radiology
6260	Aortogram	Radiology
6265	Arteriogram	Radiology
6270	Limited joint scan	Radiology
6275	Multiple joint scan	Radiology
6280	Sacro-iliac joint uptake	Radiology

Code	Description	Speciality
6285	Bile salt malabsorption scan	Radiology
6290	Partial body bone scan	Radiology
6295	Whole body bone scan	Radiology
6300	3-Phase bone scan	Radiology
6305	SPECT (Tomo) bone scan	Radiology
6310	Static brain	Radiology
6315	Dynamic brain scan	Radiology
6320	SPECT brain (CBF, Ceretec, ECD, blood pool, DAT Scan)	Radiology
6325	Static - planar cysternogram	Radiology
6330	SPECT cysternogram	Radiology
6335	Duodenal/gastric reflux	Radiology
6340	Gallium scan	Radiology
6345	Gastric emptying	Radiology
6350	G.I. bleed	Radiology
6355	G.F.R. (Tc-99m DTPA, Cr-51 EDTA)	Radiology
6360	Angiocardiogram (1st pass)	Radiology
6365	Blood pool scan (MUGA)	Radiology
6370	Exercise blood pool scan (EX. MUGA)	Radiology
6375	Dipyridamole thallium	Radiology
6380	Exercise thallium	Radiology
6385	P.Y.P. infarct scan	Radiology
6390	Anti-myosin scan	Radiology
6395	SPECT anti-myosin scan	Radiology
6400	SPECT thallium	Radiology
6410	Whole body iodine scan	Radiology
6415	Renogram	Radiology
6420	Combined renogram/GFR	Radiology
6425	Captopril renogram	Radiology

Code	Description	Speciality
6430	Diuretic renogram	Radiology
6435	DMSA renal scan	Radiology
6440	Micturating cystogram	Radiology
6445	SPECT DMSA renal scan	Radiology
6450	Colloid liver scan	Radiology
6455	HIDA liver scan	Radiology
6460	SPECT liver scan	Radiology
6465	Hepatic (liver) blood flow	Radiology
6470	Aerosol lung scan	Radiology
6475	Gallium lung scan	Radiology
6480	Lung perfusion scan	Radiology
6485	Lung ventilation scan	Radiology
6490	SPECT lung scan	Radiology
6495	Ventilation/perfusion lung scan	Radiology
6500	Lymphoscintigram	Radiology
6501	Sentinel node(s) (scintigraphy)	Radiology
6505	Marrow scan	Radiology
6510	Monoclonal antibody scan -SPECT	Radiology
6515	Monoclonal antibody scan - static	Radiology
6520	MIBG scan	Radiology
6525	Oesophageal motility study	Radiology
6530	Parathyroid scan	Radiology
6531	SPECT parathyroid scan, dual phase	Radiology
6535	Platelet scan	Radiology
6540	Salivary scan	Radiology
6545	Spleen scan	Radiology
6550	Testicular scan	Radiology
6555	Technetium scan of thyroid	Radiology

Code	Description	Speciality
6560	Iodine scan of thyroid	Radiology
6565	Thallium scan of thyroid	Radiology
6566	Bile salt absorption (ScHCAT)	Radiology
6567	Bile salt breath test	Radiology
6568	Exchangeable body sodium	Radiology
6569	I-131 Uptake (thyroid uptake)	Radiology
6570	Venogram, unilateral	Radiology
6571	I-131 Therapy (thyroid therapy)	Radiology
6572	Oestrogen receptor assay	Radiology
6573	Red cell survival	Radiology
6574	Red cell mass	Radiology
6575	Venogram, bilateral	Radiology
6576	Schilling test (urine)	Radiology
6577	Schilling test (whole body monitor)	Radiology
6578	Total body water	Radiology
6579	Total body potassium	Radiology
6580	Abdomen	Radiology
6585	Pelvimetry	Radiology
6590	Facial bones	Radiology
6595	Foramina optic	Radiology
6600	Internal auditory canals	Radiology
6605	Mandible	Radiology
6610	Mastoid	Radiology
6615	Maxilla	Radiology
6620	Nasal bones	Radiology
6625	Nasal sinuses	Radiology
6630	Orbital views	Radiology
6635	Parotid gland	Radiology

Code	Description	Speciality
6640	Pituitary fossa	Radiology
6645	Skull	Radiology
6650	Temporomandibular joint	Radiology
6655	F.B. in eye and localisation	Radiology
6660	Mammogram	Radiology
6665	X-ray neck; for F.B. in trachea or oesophagus or acute infection (e.g. epiglottitis)	Radiology
6670	Radiological examination, surgical spcimen	Radiology
6675	Angiogram (direct puncture, single vessel study, branchial, femoral) includes introduction of needles or catheter injection of contrast media and necessary pre and post injection care specifically related to the injection procedure	Radiology
6676	Placement of fiducial markers for radiation therapy guidance of prostate (via needle, any approach), single or multiple includes ultrasound guidance	Radiology
6680	Angiogram (selective catheter, single or multiple vessel study, coeliac, mesenteric, renal etc), includes introduction of needle or catheter injection of contrast media and necessary pre and post injection care realted to the injection procedure	Radiology
6681	Single selective carotid angiography and/or vertebral study	Radiology
6682	Bilateral carotid angiography study	Radiology
6683	Bilateral carotid angiography and vertebral study	Radiology
6684	Uterine artery embolisation for fibroids including angiography and fluoroscopy.	Radiology
6685	Aortogram (arch/TLA, etc.)	Radiology
6686	Biopsy of focal lesion in the liver, kidney, pancreas or spleen including embolisation (e.g. Gelfoam)	Radiology
6687	Biopsy of focal lesion, under CT guidance, in the liver, kidney, pancreas or spleen including embolisation (e.g. gelfoam)	Radiology
6688	Radiofrequency ablation of liver tumour(s) including embolisation (e.g. gelfoam)	Radiology
6690	Cavernosogram	Radiology
6691	Radiofrequency ablation of renal tumour(s) including embolisation (e.g. gelfoam)	Radiology
6692	Biopsy of lymph nodes, deep, under CT guidance	Radiology
6705	Facet arthrogram (single level)	Radiology
6706	Hepatic needle puncture/ catheterisation for biliary procedures	Radiology
6710	Portogram	Radiology
6720	Orbital venogram	Radiology

Code	Description	Speciality
6721	Spinal arteriogram	Radiology
6725	Splenoportogram	Radiology
6730	Venous sampling, adrenal, parathyroid, renal, etc.	Radiology
6735	Venogram, peripheral, single limb	Radiology
6740	Venography (selective, catheter, single vessel study and/or venous sampling, I.V.C., S.V.C., adrenal, renal, hepatic)	Radiology
6741	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, head or neck (extracranial, brachiocephalic branch) following a full assessment involving a consultants in one or more diciplines of Plastic Surgery, Dermatology, Haematology and Interventional Radiology	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 diciplines of Plastic Surgery, Dermatology, Haematology and Interventional Radiology	Radiology
6743	Image-guided percutaneous core needle biopsy, including Consultant Radiologist interpretation and report (ultrasound or stereotactic localisation) (I.P.)	Radiology
6744	Completed radiological examination and evaluation including imaging (mammography and/or ultrasound), and image-guided percutaneous core needle biopsy; where performed on same day by a Consultant Radiologist (I.P.)	Radiology
6745	Cervical	Radiology
6750	Coccyx	Radiology
6755	Complete spine	Radiology
6760	Dorsal (thoracic)	Radiology
6765	Lumbar	Radiology
6770	Sacrum	Radiology
6775	Scoliosis views	Radiology
6780	Skeletal survey	Radiology
6785	Occlusal (Intra-Oral)	Radiology
6790	Pantomogram	Radiology
6795	Tooth, single	Radiology
6800	Total Upper and Lower Jaw	Radiology
6812	Duplex scan of extracranial or intracranial arteries; unilateral or bilateral study	Radiology
6813	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or bilateral study	Radiology

Code	Description	Speciality
6814	Duplex scan of upper extremity arteries or bypass grafts; unilateral or bilateral study	Radiology
6816	Duplex scan of extremity veins including response to compression and other manoeuvres; unilateral or bilateral study	Radiology
6817	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	Radiology
6818	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study	Radiology
6950	Antegrade pyelogram	Radiology
6955	Arthrogram	Radiology
6960	Bronchial brushing	Radiology
6965	Bronchogram	Radiology
6970	Dacrocystogram	Radiology
6975	Discogram	Radiology
6985	Hysterosalpingogram	Radiology
6990	Laryngogram	Radiology
6991	Videofluoroscopy feeding study (paediatric)	Radiology
6995	Lymphangiogram	Radiology
7000	Myelogram	Radiology
7005	Myelogram (direct lateral puncture, thoracic or cervical)	Radiology
7010	Needle biopsy (trans-thoracic, bone, abdominal)	Radiology
7011	Nephrostogram	Radiology
7020	Percutaneous transhepatic cholangiogram	Radiology
7025	Per-operative cholangiogram	Radiology
7034	Imaging supervision, interpretation and report for injection procedures during cardiac catheterisation; ventricular and/or atrial angiography. Enscapsulates all guidance for the procedure including plain films	Radiology
7036	Radiological guidance during investigations or therapeutic procedure (use code 7034 for cardiology procedures) Enscapsulates all guidance for the procedure including plain films	Radiology
7037	Radiological guidance for mammographic wire guided biopsy	Radiology
7040	Retrograde pyelogram	Radiology
7051	Sialogram, Parotid	Radiology
7052	Sialogram, Submandibular	Radiology

Code	Description	Speciality
7055	Sinogram (injection of sinus tract, diagnostic)	Radiology
7065	Tomograms (+ area films)	Radiology
7070	Ventriculogram	Radiology
7071	Insertion of Contrast materials to intersoinous lumbar space to localise disc level prior to surgery under fluoroscopy with or without PA and lateral lumbar spine radiographs with or without review of CT and MRI scans followed by radiological guidance during the spinal surgery procedure	Radiology
7072	Nerve block for pain control, peripheral joints, under image guidance and confirmed by contrast injection	Radiology
7073	Nerve block for pain control, spinal region, under image guidance and confirmed by contrast injection	Radiology
8696	Consultant Radiologist In-Patient Consultation	Radiology
66744	Completed radiological examination and evaluation including imaging (mammography and/or ultrasound), and image-guided percutaneous core needle biopsy; where performed on same day by a Consulant Radiologist (I.P.)	Radiology Triple Check Assessment
6805	Biliary	Radiology Ultrasound
6810	Breast	Radiology Ultrasound
6811	Chest	Radiology Ultrasound
6835	Eye	Radiology Ultrasound
6840	Hip	Radiology Ultrasound
6841	Knee	Radiology Ultrasound
6845	Obstetrical	Radiology Ultrasound
6846	Obstetrical (with full foetal assessment)	Radiology Ultrasound
6850	Paediatric cranial	Radiology Ultrasound
6855	Pelvis	Radiology Ultrasound
6856	Parotid gland	Radiology Ultrasound
6857	Pleural space (for localisation)	Radiology Ultrasound

Code	Description	Speciality
6860	Prostate, transrectal	Radiology Ultrasound
6865	Renal (kidneys)	Radiology Ultrasound
6870	Shoulder	Radiology Ultrasound
6875	Testicular	Radiology Ultrasound
6880	Transvaginal	Radiology Ultrasound
6885	Thyroid	Radiology Ultrasound
6890	Complete abdominal ultrasound	Radiology Ultrasound
6895	Ultrasound guidance during investigations or therapeutic procedure	Radiology Ultrasound
6896	Paediatric spine (child of six months or younger)	Radiology Ultrasound
6897	Duplex scan of soft tissue (paediatric)	Radiology Ultrasound
6898	Duplex scan of veins in neck and chest (paediatric)	Radiology Ultrasound
6905	Cystogram	Radiology Ultrasound
6910	I.V.P.	Radiology Ultrasound
6915	Micturating cystogram	Radiology Ultrasound
6920	Straight renal tract (KUB)	Radiology Ultrasound
6925	Urethrogram	Radiology Ultrasound
6930	Vesiculogram	Radiology Ultrasound
8696	Consultant Radiologist In-Patient Consultation (refer to specific rule, with special reference and applicability to tertiary level hospital review only)	Radiology - CT

RADIOLOGIST SERVICES

1. In addition to the General Ground rules, the benefits payable in this section are payable subject to the general principal that. The fee is payable for:

    - The performance or personal supervision of the radiological examination.
    - Evaluation of a radiogram (or radiograms if more than one is required).
    - Written report and/or discussion with the referring doctor.
    - The apply for services supplied to listed In-Patient, Day Care or Side room procedures/ treatments that are listed in our schedule of benefits and where such service is supplied to a member who is a patient (Inpatient and / or Day Case/Side room), in a facility listed on the Aviva listed of approved hospitals / treatment centres

2. Interventional Radiologists may only claim the procedure benefit in accordance with the Ground Rules included in the Surgery and Procedures section of the SOB for the professional fees. The surgical benefit shown is inclusive of services such as ultrasound and/or ultrasound or radiological guidance. Some of the procedures, by definition, embrace lesser procedures which may be listed in their own right in the Schedule of Benefits. The lesser procedures attract benefit only when performed alone for a specific purpose but not when they form an integral part of another procedure.

3. The benefits towards Diagnostic Radiology procedures are payable in respect of Consultant Radiologists' services only, and, Radiological procedures are only payable when the radiological procedure(s) has been requested by the admitting consultant or another consultant requested to see the patient at the request of the admitting Consultant in a complex case (and where we agree to pay a Consultant consultation benefit to the second Consultant).

4. Diagnostic Radiology procedures, performed on an out-patient basis, may only be included in an out-patient claim (standard rates applicable) except for a barium enema within 42 days following procedure code 450, colonoscopy one side. The barium enema in this circumstance will be paid with the hospital claim for the colonoscopy procedure.

5. Diagnostic Radiology procedures, performed as part of a Day Case, or Side Room claim are allowable as these types of claim are considered in-patient hospital claim.

6. MRI scans benefit is subject to the following criteria:

    - Performed at a Aviva Health approved MRI centre
    - Be referred by a consultant physician/surgeon/general practitioner for benefit to apply
    - Consultant radiologist benefit for Magnetic Resonance Imaging is payable for diagnosing for out-ruling agreed medical conditions only for those clinical indications as follows: (list available on request)

    The clinical indication identifier code must be included on invoices for MRI services.

7. PET-CT (Positron Emission Tomography (incorporating Computerised Axial Tomography) Scan, benefit is subject to the following criteria:

    - Prior approval must be sought from Aviva Health
    - The member is referred for a PET-CT scan by an Aviva Health registered consultant
    - The PET-CT scan is carried out at a PET-CT facility approved by Aviva Health for the purposes of providing benefit for our members
    - The PET-CT scan is carried out for one of the clinical indications specified (list available on request)

8. For hospitals which operate through the Aviva direct settlement of hospital and associated consultant professional fee charges, the claiming of radiology benefit will continue on the basis of a fully completed and collated Aviva claim form as completed by the admitting consultant surgeon/physician, which will be submitted by the hospital in conjunction with its own invoice for services provided. However, in **exceptional circumstances** when unforeseen delays occur in the submission of a claim in excess of three months from the date of test/service due to extenuating circumstances,the Consultant Radiologist may submit to Aviva Health, a completed claim form which must include side 1 of the form completed and signed by the Aviva member, side 2 of the claim form completed in as far as is possible by an attending Consultant, to comprise clinical data including member Discharge Summary (where available),and all other invoices related to the admission are attached to the claim i.e. Hospital and other Secondary Consultants. This exception may not be availed of, for routine bill submission due to routine or on-going completion delays by either the submitting hospital or the admitting consultant. For a specific Consultant (or Consultant Group) to avail of this facility they must notify the Claims Manager of Aviva Health explaining the reason for the use of this exception to ensure that issues arising from the use of this exemption are maintained at a minimal level.

9. The benefit for interventional radiological procedures is inclusive of ultrasound or radiological guidance.

10. The code of the precise investigation(s) carried out and the date of the test(s) must be reported on the invoice to Aviva Health.

CONSULTANT RADIOLOGIST IN-PATIENT CONSULTATION

An in patient consultation is payable to a consultant radiologist where the patient is transferred from one hospital to another and admitted to the second hospital for tertiary level care arising from a complicated illness, e. g, oncology, neurosurgery, serious trauma, etc. It involves a complete evaluation of the original radiological results in associating with any additional clinical work-up necessary in the second hospital including the provision of a written report from the consultant radiologist. (Additional radiology procedures performed in the second hospital may be claimed separately).

Code	Description
8696	Consultant Radiologist In-Patient Consultation

MRI CODES & RATES

Description	Without Contrast	With Contrast	Without Contrast		With Contrast	
			Radiologist Participating	Radiologist Standard	Radiologist Participating	Radiologist Standard
6230	Magnetic resonance imaging		New code	6230	Magnetic resonance imaging	Radiology - MRI
6231	Magnetic resonance imaging with contrast enhancement		New code	6231	Magnetic resonance imaging with contrast enhancement	Radiology - MRI

Description	Without Contrast	With Contrast
Head		
for exclusion, further investigation and monitering of;		
Tumour of the brain or meninges	62300001	62310001
Skull base or orbital tumour	62300011	62310011
Acoustic neuroma	62300021	62310021
Pituitary tumour	62300031	62310031
Inflammation of the brain or meninges	62300041	62310041
Encephalopathy	62300051	62310051
Encephalitis	62300061	62310061
Suspect leukodystrophies	62300071	62310071
ENT problems – following consultation with a radiologist	62300081	62310081
Demyelinating disease of the brain	62300091	62310091
Congenital malformation of brain or meninges	62300101	62310101
Venous sinus thrombosis	62300111	62310111

Description	Without Contrast	With Contrast
For further investigation and monitoring of:		
Head trauma	62300131	62310131
Epilepsy	62300141	62310141
Stroke	62300151	62310151
Post-operative follow-up after brain surgery	62300161	62310161
Severe headaches – exclude aneurysm	62300171	62310171

Ophthalmic		
For further investigation and monitoring of:		
Suspected intra-orbital or visual pathway lesions	62300301	62310301
Dysthyroid eye disease	62300311	62310311
Diplopia	62300321	62310321

Spine		
for exclusion, further investigation and monitering of;		
Tumour of the CNS or meninges	62300401	62310401
Inflammation of the CNS or meninges	62300411	62310411
Demyelinating disease	62300421	62310421
Spinal cord compression (acute)	62300431	62310431
Congenital malformations of the spinal cord, cauda equina or meninges	62300441	62310441
Syrinx – congenital or acquired	62300451	62310451
Myelopathy	62300461	62310461
For further investigation and monitoring of:		
Cervical radiculopathy with neurological signs	62300711	62310711
Thoracic radiculopathy with neurological signs	62300721	62310721
Lumbar radiculopathy with neurological signs	62300731	62310731
Spinal canal stenosis	62300741	62310741

Description	Without Contrast	With Contrast
Previous spinal surgery	62300751	62310751
Trauma	62300761	62310761
Cervical Spine – Severe neck pain	62300771	62310771
Thoracic Spine – Severe thoracic pain	62300781	62310781
Lumbar Spine – Severe low back pain	62300791	62310791
for investigation of;		
Any cause of spinal disease in pregnancy	62300901	62310901

Musculoskeletal System		
for exclusion, further investigation and monitering of;		
Tumour arising in bone or other connective tissue	62301001	62311001
Infection arising in bone or other connective tissue	62301011	62311011
Osteonecrosis	62301021	62311021
Derangement of the hip or their supporting structures	62301031	62311031
Knee	62301032	62311032
Hand	62301033	62311033
Other MSK not specified	62301034	62311034
Derangement of the knee, or their supporting structures	62301041	62311041
Derangement of the ankle or their supporting structures	62301051	62311051
Derangement of the shoulder or their supporting structures	62301061	62311061
Derangement of the elbow or their supporting structures	62301071	62311071
Derangement of the wrist joints or their supporting structures	62301081	62311081
For further investigation and monitoring of:		
Slipped upper femoral epiphysis	62301101	62311101
Post inflammatory or post traumatic epiphyseal fusion in a person under 16 years of age	62301111	62311111
Complex cases of juvenile dermatomyositis	62301121	62311121

Description	Without Contrast	With Contrast
Gaucher's disease	62301131	62311131
for investigation of;		
Juvenile dermatomyositis by guiding biopsy	62301151	62311151

Cardiovascular System		
For further investigation and monitoring of:		
Congenital heart disease	62301201	62311201
Tumour of the heart or a great vessel	62301211	62311211
Aortic dissection/aneurysm	62301221	62311221
Abnormality of thoracic aorta	62301231	62311231
Post operative aortic graft infection or dehiscence	62301241	62311241
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	62301251	62311251

Abdomen		
Characterisation of liver lesions when an ultrasound report is suggestive of haemangioma	62301311	62311311
Detection and/or characterization of liver lesions	62301321	62311321
Staging of abdominal masses where CT is inconclusive	62301331	62311331
Evaluation of uterine fibroids, if Embolisation of uterine fibroids being contemplated, not in routine assessment for fibroids	62301341	62311341
Staging of gynaecologic malignancies (endometrial, cervical and ovarian)	62301351	62311351
Staging of rectal cancer	62301361	62311361
Post operative recurrence of rectal cancer following CT and if tissue remains	62301371	62311371
Staging of bladder cancer	62301381	62311381
Detection of small pancreatic tumors not visible by CT, only if negative high resolution Triphassic CT scan of pancreas	62301391	62311391

Description	Without Contrast	With Contrast
Assessment of fisulae/abcesses in patients with established Chron's disease following discussion with a multi-disciplinary team	62301401	62311401
for post operative evaluation of		
Perineal abscess	62301501	62311501
Perineal fistula	62301511	62311511
Assessment of the inferior vena cava in patients with known solid renal tumour	62301531	62311531
MR urography (MRU) in patients with urographic contrast allergy	62301551	62311551
MR urography in pregnancy	62301561	62311561

Magnetic Resonance Cholangiopancreatography (MRCP)		
for further investigation of;		
Pancreatic and biliary disease where conventional methodology has failed and ERCP is considered undesirable	62301601	62311601

Magnetic Resonance Angiography (MRA)		
for exclusion or further investigation of;		
Stroke	62301701	62311701
Carotid and vertebro-basilar disease	62301711	62311711
Carotid or vertebral artery dissection	62301721	62311721
Intracranial aneurysm	62301731	62311731
Intracranial arteriovenous malformation	62301741	62311741
Venous sinus thrombosis	62301751	62311751
Vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium	62301761	62311761
Obstruction of the superior vena cava, inferior vena cava or a major pelvic vein	62301771	62311771
for exclusion of;		
Renal artery stenosis post renal transplant	62301791	62311791

Description	Without Contrast	With Contrast
Renal artery stenosis in patients less than 40 years of age with onset of significant hypertension and associated clinical laboratory or imaging evidence to suggest renal artery stenosis	62301801	62311801

Carotid and Vertebral		
For investigation of transient ischaemic episodes, only following an inconclusive ultrasound (Note diagnostic use is not covered)	62301901	62311901

Peripheral		
Investigation of intermittent claudication or critical limb ischemia	62302001	62312001

Renal		
Investigation of patients with hypertension	62302101	62312101

Mesenteric		
Investigation of patients with suspected mesenteric angina, only following an inconclusive ultrasound (Note diagnostic use is not covered)	62302201	62312201

Aortic Arch		
Investigation of patients with transient ischaemic episodes / CVA or upper limb ishaemia.	62302301	62312301
Investigation of patients with aneurysms, dissection , arteriovenous fistulae or coarctation	62302311	62312311

Magnetic Resonance Venography (MRV)		
for exclusion or further investigation of;		
Patients with suspected stenosis or occlusion of central veins.	62302401	62312401
Patients with suspected thrombus in IVC or iliac veins, only following an inconclusive ultrasound	62302411	62312411
Patients with venous anomalies	62302421	62312421

Description	Without Contrast	With Contrast
Body		
For further investigation of;		
Malignant soft tissue tumours for diagnosis and staging	62302501	62312501
Congenital uterine or anorectal abnormality	62302521	62312521

Whole Body		
Bone Metastases due to primary cancer	62302601	62312601
Investigation of Polymyalgia, if pathology suggests diagnosis	62302611	62312611
Investigation of infiltrating marrow disorders	62302621	62312621

Breast		
Breast Cancer- where mammogram and/or ultrasound are negative for pathology but therte continues to be a high index of clinical suspicion (e.g. in persons with inherited BRCA1 and BRCA2 mutations	62307001	62317001

Other		
Cardiac magnetic resonance imaging (MRI) with or without contrast enhancement (Refer to attached rules).	6233	
Paedriatric 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 contast quanticification of great vessel AV valve outflow tract flow, ventricular volumes, angiography, three dimensional image reconstruction, tissue tagging and delayed gadolinium enhancement of myocardium, including imagaing acquisition, post-processing of volume and flow data. report of MRI MRA.	6234	
Breast biopsy with the use of MRI to guide localisation of breast lesion(s) which cannot be visualised with mammography or ultrasonography (I.P.)	6746	

CT CODES & RATES

Description	Without Contrast	With Contrast
	Code	Code
Computed tomographic angiography, with or without contrast material(s), all sections including image post processing, pulmonary	6101	6101
Brain, without contrast material	6102	6103
Orbit, sella or outer, middle, or inner ear; without contrast material	6104	6106
Maxillofacial area, without contrast material	6107	6108
Thorax, without contrast material	6109	6112
CAT scanning for biopsy or drainage	6111	
High resolution, lungs	6113	
Abdomen (including pelvis)	6114	6116
CT Colonography	6123	
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.)	6124	
Computed tomographic (CT) coronary angiography, with or without contrast material(s), all sections, including image post processing	6222	
C.T. scanogram of lower limbs (paediatric)	6223	
Long bones	6226	
Joints	6227	
Spine	6228	6224
Feet/Hands	6229	

PET/CT CODES

Code	Description
Lung Cancer	
7701	Lung Cancer (NSCLC) Nodal Staging
7702	Lung Cancer (NSCLC) Metastatic - Staging
7703	Lung Cancer (NSCLC) Recurrence
7712	Lung Cancer (Small Cell) Recurrence
7713	Lung Cancer (Small Cell) - Therapy Control
7720	Solitary Pulmonary Nodule (SPN) Diagnosis
7730	Pulmonary mass lesions (only those that are too risky to biopsy) - Diagnosis
Colorectal Cancer	
7741	Colorectal Cancer - Nodal Staging
7742	Colorectal Cancer - Metastatic Staging
7743	Colorectal Cancer - Recurrent
Oesophageal Cancer	
7750	Oesophageal Cancer - Diagnosis
7751	Oesophageal Cancer - Nodal Staging
7752	Oesophageal Cancer - Metastatic Staging
7753	Oesophageal Cancer - Recurrent
Pancreatic Cancer	
7763	Pancreatic Cancer - Recurrent
Malignant Melanoma	
7771	Malignant Melanoma - Nodal Staging
7772	Malignant Melanoma - Metastatic Staging

Code	Description
7773	Malignant Melanoma - Recurrent

Lymphoma	
7781	Lymphoma - Hodgkin's Nodal Staging
7782	Lymphoma - Hodgkin's Metastatic Staging
7783	Lymphoma - Hodgkin's Recurrence
7784	Lymphoma - Hodgkin's Therapy Control
7791	Lymphoma - High Grade Non Hodgkins - Nodal Staging
7792	Lymphoma - High Grade Non Hodgkins - Metastatic Staging
7793	Lymphoma - High Grade Non Hodgkins - Recurrence
7794	Lymphoma - High Grade Non Hodgkins - Therapy Control
7801	Lymphoma - Low Grade Non Hodgkins - Nodal Staging
7802	Lymphoma - Low Grade Non Hodgkins - Metastatic Staging
7803	Lymphoma - Low Grade Non Hodgkins - Recurrence
7804	Lymphoma - Low Grade Non Hodgkins - Therapy Control

Head and Neck Cancer	
7811	Head Cancer Nodal Staging
7812	Head Cancer Metastatic Staging
7813	Head Cancer Recurrence
7814	Head Cancer Therapy Control
7821	Neck Cancer Nodal Staging
7822	Neck Cancer Metastatic Staging
7823	Neck Cancer Recurrence
7824	Neck Cancer Therapy Control

Cervical Cancer	
7831	Cervical Cancer Metastatic Staging - limited to suspected remote metastases based on other imaging techniques
7832	Cervical Cancer Recurrence - limited to suspected remote metastases based on other imaging techniques

Code	Description
7833	Cervical Cancer Therapy Control - limited to suspected remote metastases based on other imaging techniques

Unknown Primary	
7840	Unknown Primary Tumour Diagnosis

Breast Cancer	
7851	Breast Cancer Nodal Staging -(not for axillary node evaluation)
7852	Breast Cancer Metastatic Staging -(not for axillary node evaluation)
7853	Breast Cancer Recurrence -(not for axillary node evaluation)
7854	Breast Cancer Therapy Control -(not for axillary node evaluation)

Brain Tumours	
7863	Brain Tumour - Recurrent

Brain Tumours	
7873	Ovarian Tumour & Cervical Cancer - Recurrent
7875	Ovarian Cancer - Restaging of previously treated women with a rising CA125 level, who have a negative or equivocal conventional imaging CT or MRI

Brain Tumours	
7883	Bone & Soft Tissue Tumour - Recurrent
7892	Differentiated Thyroid Cancer Metastatic Staging
7900	Alzheimers Dementia Diagnosis - only where CT/MRI are negative
7905	Myocardial Viability
7910	Cardiomyopathy - differential diagnosis
7925	Focal/Temporal Lobe Epilepsy
7945	Testicular Cancer - restaging of men with previously treated disease for the purpose of detecting residual disease suspected recurrence or to determine the extent of recurrence

"Any procedure not listed above but appearing upon the Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996 (as amended) shall be reimbursed, were performed, at the rate set out within those regulations, in euro"

INDEX