Irish Life health

Schedule of Benefits

for Professional Services

Aug 2014

Contents

Schedule of Benefits for Professional Services from Irish Life Health

Welcome to Irish Life Health's Schedule of Benefits.

This book displays the professional services for all medical, surgical and diagnostic procedures and tests covered by health insurance from Irish Life Health for inpatient and day case as set out in the rules of Irish Life Health dac.

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 Irish Life Health customer care agent.

For further information or queries; please contact us:

By telephone at 1850 718 718

By email on partnersupport@irishlifehealth.ie

Our dedicated provider website www.irishlifehealth.ie/medical-providers

In writing to Irish Life Health, PO Box 764, Togher, Cork

Thank you,

Colm O'Sullivan,
Head of Provider Affairs,
Irish Life Health dac

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General Ground Rules

1. This Schedule of Benefits for Professional Services outlines the professional fee services and benefits available from Irish Life Health to *Consultants who are registered with Irish Life Health for the treatment of private patients for medically necessary procedures in an Irish Life Health approved hospital or treatment centre.
2. Medically necessary means treatment or a hospital stay as defined in the Irish Life Health 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, not furnished primarily for the convenience of the patient, the doctor or other provider. 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 Irish Life Health 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 services are those 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 Irish Life Health approved facility, in an Irish Life Health approved hospital or treatment centre listed in the Irish Life Health Directory of Hospitals.
4. This professional service schedule lists procedures/treatments and where that specific service can be provided in an Irish Life Health approved hospital or treatment centre listed in the Irish Life Health Directory of Hospitals and where the Irish Life Health has contracted with the Consultant(s) and hospital.
5. Approved hospitals and treatment centres are those facilities that Irish Life Health recognise for the purpose of providing treatment to Irish Life Health members where the specific technology and services approved and subject to the Rules, Terms and Conditions of Membership that apply to the patient' 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 services 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 Irish Life Health 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. You may include supplementary reports with the claim form if necessary. This will greatly assist Irish Life Health 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 Irish Life Health for that specific Consultant.

16. The procedures and services are 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. Irish Life Health will not provide benefit for procedures that are regarded as experimental, or a clinical trial, unless agreed in advance with Irish Life Health.

20. All new procedures and medical services should be notified to Irish Life Health and will be evaluated in consultation with Irish Life Health's Medical Advisors. Following evaluation where Irish Life Health 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 Irish Life Health. Any charges made are, therefore, a matter between the patient and the consultant.

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

22. The basis for claiming professional benefits is the completed Irish Life Health 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
- Irish Life Health doctor code
- PPS number
- Reference/invoice number
- Patient's name and address
- Irish Life Health 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 – 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 Irish Life Health direct settlement of hospital and associated consultant charges, the claiming of Pathologist or Radiologist benefit will continue on the basis of a fully completed and collated Irish Life Health 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 Irish Life Health, a completed claim form which must include side 1 of the form completed and signed by the Irish Life Health 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 Irish Life 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 Services 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 Irish Life Health throughout the term of this agreement. Any such changes will be notified on the web site of Irish Life Health and/or directly to the consultant(s) involved.

27. Irish Life Health 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 Irish Life Health member is treated under a consultant in an admitting approved Irish Life Health hospital and is then transferred to another Irish Life Health approved hospital for a surgical or diagnostic procedure under the care of the same admitting or treating consultant, for the purpose of professional benefits 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 so far as is possible to procedures and treatments performed on Irish Life Health members. Any deviation from the above guidelines will be notified to Irish Life Health at time of claim to validate the medical necessity of the performance of the procedure / treatment.

*A 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. For details of eligibility of payment please refer to your Contract with Irish Life Health.

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Surgery and Procedure 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 CONSULTATION

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 Irish Life Health member benefit (subject to the member policy held).

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

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

No further outpatient consultation fee should be incurred by the Irish Life Health 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 Services.

Additional procedures which are applicable for direct settlement of fees are:

Day-To-Day Benefits and Out-Patient Benefits	
CODE	**DESCRIPTION**
1587	Laser treatment to port wine stains only, one or more sessions, plus photographic evidence to be supplied with claim
2147	CO2 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 (e.g. 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 Irish Life Health'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 on the same day 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 Irish Life Health 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:

a) It is the only treatment given or

b) 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 Irish Life Health 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 >40.

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 Irish Life Health Medical Advisors. If agreed by Irish Life Health, we will pay the approved hospital benefits. However, if not approved, the hospital will only be paid the Irish Life Health Side Room hospital benefit.

Professional fee benefits are not affected by this designation. This will only apply in an Irish Life Health 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
- That where a group Consultant Pathologist practice does not cover all Pathologists in a particular hospital, that this supervisory fee is NOT paid as this non-payment may encourage the relevant consultants to operate in a harmonious, patient centred manner.
- 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 Irish Life Health 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 Irish Life Health's Medical/Dental Advisors prior to being performed, as listed throughout the Schedule of Benefits for Professional Services.

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 IRISH LIFE HEALTH IN CONDITIONS OF PAYMENT

If a Consultant decides to carry out a procedure which does not comply with the Irish Life Health'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 Irish Life Health. 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 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 reoccurrence 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 reoccurring 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 under differentiated 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 associated 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 Irish Life Health and have completed fellowship training in Mohs surgery.*

30. CARDIOLOGY

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

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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 trans oesophageal 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 Irish Life Health 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 (MAC).

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

(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.

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 Irish Life Health.

(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 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 Irish Life Health 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 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 Irish Life Health. The decision made by the monitoring group is final.

7. CLAIMING BENEFIT

For hospitals which operate through the Irish Life Health 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 Irish Life Health 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 Irish Life Health, a completed claim form which must include side 1 of the form completed and signed by the Irish Life Health 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 Irish Life 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.

8. ANAESTHESIA BLOCK PROCEDURES

CODE	DESCRIPTION
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.

4

Emergency Medical Admission and Conditions for Neonates or Paediatric Care

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. consultation of a non-emergency case.

CODE	DESCRIPTION (TRUNCATED)	SPECIALTY
10000	Medical management for specific paediatric medical day care procedures/investigations	In-patient attendance and other medical services

5

In Patient Geriatric Medicine

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 Irish Life Health 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 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 Irish Life Health claim form from the primary treating consultant.

6

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 Irish Life Health. The benefits relate to the medical management of appropriately admitted patients to an Irish Life Health 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

Irish Life Health 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 designated consultant as medical director supported by other suitable qualified consultants with allocated intensive care sessions providing 24 hour 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 Irish Life Health 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 physiological 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 Irish Life Health 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 Irish Life Health 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 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 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 (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, PCAs and/or epidurals
- IV drugs
- Vaso-active agents
- 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

*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.

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

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

INTENSIVE CARE MEDICINE AGREED ICU BEDS

The Intensive Care Medicine Benefits are only applicable to patients in receipt of intensive care in the agreed intensive care beds in the hospitals listed below.

COUNTY	HOSPITAL NAME
Cavan	Cavan General Hospital
Cork	Bantry General Hospital; Mercy Hospital; Cork University Hospital; South Infirmary/Victoria Hospital
Donegal	Letterkenny General Hospital
Dublin	The Adelaide and Meath Hospital Dublin incorporating The National Children's Hospital Tallaght; St. Vincent's Hospital Elm Park; St. James's Hospital; Mater Misericordiae Hospital; Connolly Hospital Blanchardstown; Beaumont Hospital; Beacon Hospital; Mater Private Hospital; Blackrock Clinic.
Galway	University Hospital Galway; Portiuncla Hospital Ballinasloe; Galway Clinic.
Kerry	Tralee General Hospital
Kildare	Naas General Hospita
Kilkenny	St. Luke's General Hospital
Laois	Midland Regional Hospital Portlaoise
Limerick	Mid-Western Regional Hospital Dooradoyle; St. John's Hospita
Louth	Our Lady of Lourdes Hospital Drogheda; County Hospital Dundalk
Mayo	Mayo General Hospital Castlebar
Offaly	Midland Regional Hospital Tullamore
Sligo	General Hospital Sligo
Tipperary	
Waterford	Waterford Regional Hospital
Westmeath	Midlands Regional Hospital
Wexford	Wexford General Hospital

7

Paediatric Intensive Care

1. PAEDIATRIC INTENSIVE CARE MEDICINE BENEFIT

Paediatric intensive care benefits are payable to Consultant Paediatric Intensivist who is registered as such with Irish Life Health, and who are attached to a Paediatric Intensive Care Unit registered with Irish Life Health, 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 inpatient 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 Irish Life Health 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:

- Continuous ECG display and heart monitoring
- Continuous direct arterial blood pressure monitoring
- Continuous central venous and/or pulmonary arterial pressure monitoring
- Continuous ventilator and oxygen monitoring
- Ventilator disconnection alarms
- Continuous inspired oxygen concentration monitoring
- Continuous central temperature monitoring
- Cardiac output measurement

Each PICU unit should have access to equipment for:

- Resuscitation
- Blood gas analysis (on the Paediatric unit by unit staff)
- Portable X-rays

- Ultrasound scanning
- 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 Irish Life Health approved PICU.

The eligible cases will be:

- Patients with 2 organ failures which may include possible respiratory failure
- 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)
- Patients receiving mechanical ventilation support
- Patients requiring complex or potentially harmful interventions
    i. renal placement therapy, plasma exchange or similar extra-corporeal therapies
    ii. Infusion of an inotrope, pulmonary vasodilator, prostaglandin or cardiac antiarrhythmic medications and for 24 hours afterwards
    iii. Infusion of anti-hypertensive medication
    iv. Infusion of medication which may cause wide fluctuations in cardiac output
    v. Infusion of a bronchodilator
    vi. Infusion of a central nervous system depressant or any medication that may decrease respiratory minute ventilation or level of consciousness
    vii. 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
- A child recovering from major surgery who is anticipated to have large flux in circulating blood volume or with potential to require further infusion of blood, colloid or crystalloid solutions
- Exchange transfusion
- A child recovering form complex surgery to the airway or who has an instable airway
- A child following major trauma with an injury severity (or similar) score over 8
- 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
- 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
- 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.

Elective post-operative admission

Where PICU admission is planned post-operatively due to clinical instability, is overnight and does not exceed 24 hours

CODE	DESCRIPTION
10011	Elective post-operative night medical admission for neonates

PAEDIATRIC INTENSIVE CARE MEDICINE BENEFITS

Consultations

Consultation benefit is payable to the paediatric intensive care Consultant for a patient being assessed for admission to the intensive care unit as defined in Intensive Care Medicine, ground rule 2 and where it is deemed that the patient does not require admission to the intensive care unit.

Other procedures for which additional benefit is payable

The following procedures are payable in addition to the PICU Medicine Benefit where the service is provided during a patient's stay in the PICU

5091 Cardioversion

5109 Echocardiography, transoesophageal

5952 Insertion of a tube drain into the pleural cavity

5251 Closed drainage of pneumothorax

5760 Lumbar puncture

*1626 Insertion of tunnelled central venous access with externalised catheter end (see note below)

*1634 Placement of non-tunnelled central venous catheter (peripherally or centrally inserted)

5065 Insertion or replacement of temporary transvenous single chamber cardiac electrode.

**Note to qualify as central venous access the tip of the catheter/device must terminate in the subclavian, brachiocephalic or iliac vein, the vena cava or right atrium.*

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

8

Palliative Medicine Benefit

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 Irish Life Health 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 inpatient consultation rate).

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 In-patient 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.*

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 Irish Life Health claim form from the primary treating consultant.

9

Medical

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 inpatient 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 Irish Life Health'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
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

9. INPATIENT ATTENDANCE RULES

In patient consultation

An 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
11066	An 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:

1. pre-operative assessment - clinical examination and/or laboratory/radiological,
2. cardiac investigations – identifies an undiagnosed acute problem that requires medical
3. management prior to anaesthesia (e.g. hypertension, cardiac arrhythmia, diabetes).
4. Patients with insulin dependent diabetes and
5. 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, not 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

An in-patient neurological Consultation arising from the referral of a patient by the admitting Consultant to a Consultant Neurologist registered with Irish Life Health 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 outpatient 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 outpatient 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, postoperative care including evaluation of all necessary tests) where the Irish Life Health member is admitted under consultant care for one of the procedures listed below and where the procedure is performed by another Consultant in a different speciality is as follows;

CODE	DESCRIPTION
8693	Day care Inpatient 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 imageguided 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 related 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 CONSULTATION

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 Irish Life Health 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 Irish Life Health to the Consultant by means of the direct settlement system.

For purposes of clarity, the Consultant may charge the Irish Life Health 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 Irish Life Health for inclusion in their annual out-patient claim subject to the member policy held).

No further outpatient consultation fee should be incurred by the Irish Life Health 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.

Additional procedures which are applicable for direct settlement of fees are:

1587	Laser treatment to port wine stains only, one or more sessions, plus photographic evidence to be supplied with claim
2147	CO2 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 Irish Life Health laboratory facility
5880	EMG - in an approved Irish Life 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 Irish Life Health 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 Irish Life Health 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 Irish Life Health 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 Irish Life Health 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 Irish Life Health, a completed claim form which must include side 1 of the form completed and signed

by the Irish Life Health 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 Irish Life 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.

19.1. 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 new-born 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

19.2. 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 new-born associated with cyanosis and heart failure
8455	Hypotensive shock
8460	Hypertensive crisis
8465	Cardiac arrest
8470	Acute bacterial endocarditis (myocarditis or pericarditis)

19.3. 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 new-born 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

19.4. 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
8515	Reye's syndrome

19.5. Diseases of the Genitourinary system

8520	Acute renal failure

19.6. 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

19.7. Diseases of the Blood, Lymphatic system

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

19.8. 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

19.9. Other Reasons

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

10

Neonatology and Neonatology Intensive Care

1. INTENSIVE CARE MEDICINE BENEFIT

Neonatal intensive care benefits are payable to Consultant Neonatologists and Consultant Paediatricians who are registered with Irish Life Health, and who are attached to a Neonatal Intensive Care Unit registered with Irish Life Health 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 Irish Life Health 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
  iii. 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 Irish Life Health 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:

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

  vii. Full exchange transfusion

  viii. Peritoneal dialysis

  ix. Infusion of an inotrope, pulmonary vasodilator or prostaglandin and for 24 hours afterwards
- 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
- 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
- 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 any 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 agree, 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 inservice 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 an 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 Irish Life Health 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 Irish Life Health 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.

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. CONSULTATION BENEFIT FOR INPATIENT NEONATOLOGIST OR PAEDIATRICIAN CONSULTATION

An 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 18.00hrs and 09.00hrs. 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 In-Patient Consultation

11

Periodontal/ Oral/Dental Surgery Ground Rules

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 Irish Life 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 Irish Life Health

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

2. ORAL SURGEONS

2.1. Have the option of participating with Irish Life 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 Irish Life 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 Irish Life Health

2.3.4. Where a General Anaesthetic is required it will be liable for cover when performed in a listed Irish Life Health fully participating Hospital, under the supervision of a Consultant Anaesthetist who is fully participating with Irish Life Health 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 Irish Life Health member, this may only be administered in an Irish Life Health 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 Irish Life Health 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 Irish Life Health professional fee only will be paid.

Where an Oral surgeon elects to be registered with Irish Life Health 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 Irish Life Health approved hospital, then the agreed hospital fee shall also be paid to the hospital concerned

3. PERIODONTAL SURGEONS

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

3.2. Are covered for the range of procedures as per attached schedule.

3.3. For Periodontists to be registered with Irish Life Health:

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

3.3.2. To be eligible to be on the Irish Life Health 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 course accredited by the European Federation of Periodontists

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

3.3.4. They must supply a copy of the above registration annually to Irish Life Health

3.3.5. Where a General Anaesthetic is required it will be liable for cover when performed in a listed Irish Life Health fully participating Hospital, under the supervision of a Consultant Anaesthetist who is fully participating with Irish Life Health 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 Irish Life Health member, this may only be administered in an Irish Life Health participating hospital, or in the private practice of an Periodontist as registered above

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

3.3.8. Where the Peridontist elects to be registered with Irish Life Health 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 Periodontsis for the performance (both professional fee and any technical or facility fee) for the procedure(s). Where such a procedure is performed in an Irish Life Health 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

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
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
3020	Simple cysts or epulis, palate or floor of mouth, excision of
3025	Small tumours of dental origin, removal of, includes biopsy

Periodontal Procedures

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
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

12 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 Irish Life Health for day care admission in a Irish Life Health 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 on-going 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 Irish Life Health claim form from the primary treating consultant.

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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 inpatient. 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 radiotherapy benefit will be on the basis of a fully completed Irish Life 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 Irish Life Health, a fully completed claim form duly signed by the Irish Life 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 followup out-patient consultation after the course of treatment has been completed.

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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 subspecialities in which most of these investigations are carried out. Irish Life Health 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 Irish Life Health in order that benefit may be paid.
6. Pathology investigations performed on an out-patient basis, may only be included in an outpatient 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 Irish Life Health 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 Irish Life Health 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 Irish Life Health, a completed claim form which must include side 1 of the form completed and signed by the Irish Life Health 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 Irish Life 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)

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Radiologist Services

1. 1. In addition to the General Ground rules, the benefits payable in this section are payable subject to the general principle that:
   - The procedure is performed or personally supervised by the claiming radiologist.
   - Written report and/or discussion with the referring doctor.
   - Is restricted to the procedures listed in the Schedule of Benefits and carried out in approved facilities for inpatients.
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 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 or CT Colongraphy within 42 days following procedure code 450,454 or 456 (colonoscopy one side or incomplete colonoscopy). The barium enema or CT Colonography 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 Irish Life 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 or out-ruling agreed medical conditions only for those clinical indications listed. (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 Irish Life Health.
   - The member is referred for a PET-CT scan by an Irish Life Health registered consultant.
   - The PET-CT scan is carried out at a PET-CT facility approved by Irish Life 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 Irish Life Health 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 Irish Life Health 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 Irish Life Health, a completed claim form which must include side 1 of the form completed and signed by the Irish Life Health member, side 2 of the claim form completed in as far as is possible by an attending Consultant (including a Consultant Radiologist involved in the care of the patient), 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 Irish Life 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 Irish Life 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

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In Patient Psychiatry

An inpatient psychiatric consultation arising from the referral of a patient by the admitting Consultant to a Consultant Psychiatrist registered with Irish Life Health.

(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 usual consultation rates).

The consultation includes:

- Psychiatric diagnostic interview examination including a full medical and psychiatric history
- Mental status, and a disposition evaluation
- Ordering and medical interpretation of laboratory or other medical diagnostic studies
- Giving an opinion and making an appropriate record
- The duration for this consultation must be for a minimum of 50 minutes

CODE	DESCRIPTION
10068	A major inpatient psychiatric consultation

The benefit for Inpatient 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.

Consultation benefit is not payable to consultants within the same speciality as the admitting consultant. Multiple consultation benefits are not payable to consultants of the same speciality. A consultant benefit is not payable to a consultant if a diagnostic procedure is payable to another consultant, both consultants having the same speciality.

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.

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. 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 Irish Life Health claim form from the primary treating consultant.

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Orthopaedic Operations

Ankle

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3955	Arthrodesis of ankle joint		
3956	Arthroscopy, ankle, with or without removal of loose body or foreign body, with or without synovectomy, debridement	Daycare, I.P.	
3957	Arthroplasty (ankle) (IP)	I.P.	
3958	Arthroplasty, ankle with implant (total ankle)(IP)	I.P.	
3959	Arthroplasty, ankle revision, total ankle (IP) I.P.		
3965	Fracture of medial or lateral malleolus (1st degree Pott's fracture), internal fixation of		
3970	Fracture of posterior malleolus without fracture of other malleolus, internal fixation of		
3971	Open treatment of bimalleolar ankle fracture, with or without internal fixation		
3972	Fracture of trimalleolar ankle fracture with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip		
3975	Fracture, Pott's, closed reduction of		
3976	Closed reduction manipulation of dislocated ankle joint, with or without percutaneous skeletal fixation such as pins		
3980	Synovectomy and debridement	Daycare	
3985	Synovial biopsy, ankle	Diagnostic, Daycare	
3986	Talar fracture, open reduction and internal fixation of		
3990	Tendon, achilles, elongation of		
3995	Tendon, achilles, repair of		
4000	Tendon transplants about the ankle joint and foot (multiple)		
4005	Tendon transplants about the ankle joint and foot (single)		
4010	Traumatic fracture and dislocation, open reduction of		
4015	Unstable ankle, Watson Jones operation for		
3961	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect (I.P.)	I.P.	
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., 1 Night Only	
3963	Arthroscopy, subtalar joint, surgical, with subtalar arthrodesis (I.P.)	I.P.	

Congenital Talipes Equinovarus

4019	Astragalectomy		
4020	Dwyer's Valgus osteotomy		
4025	Manipulation and plaster fixation	Daycare	
4030	Manipulation and strapping	Daycare	
4035	Rotation osteotomy of tibia		
4040	Soft tissue release		
4045	Tarsal osteotomy		
4050	Tendon transplant, single		
4051	Tendon transplant, multiple		

Foot

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
4060	Arthrodesis of all inter phalangeal joints (Lambrinudi), unilateral		
4065	Arthrodesis of all inter phalangeal joints (Lambrinudi), bilateral		
4070	Arthrodesis of first metatarso phalangeal joint (I.P.)	I.P.	
4075	Arthrodesis triple, in all its forms		
4080	Arthrodesis, pantalar		
4085	Claw foot (Steindlar), muscle stripping, operations for		
4090	Exostosis of first metatarsal, unilateral, removal of	1 Night Only	5.01
4095	Exostosis of first metatarsal, bilateral, removal of		5.02
4100	Flat foot involving joint fusion, operation for		
4101	Flexor tenotomy, single (foot)	Daycare	
4102	Flexor tenotomy, multiple (foot)	Daycare	
4103	Fracture of hind foot, internal fixation, unilateral		
4104	Fracture of hind foot, internal fixation, bilateral		
4105	Fracture of phalanges and/or metatarsals, closed reduction of (I.P.)	I.P., Daycare	
4106	Open treatment (hind foot) of calcaneal or talus fracture with or without internal or external fixation		
4107	Percutaneous skeletal fixation of metatarsal fracture with manipulation		
4108	Open treatment of metatarsal fracture, with or without internal or external fixation		
4110	Fracture of phalanx and/or metatarsal, single, internal fixation of		5.03
4115	Fracture of phalanges and/or metatarsals, multiple, internal fixation of		
4120	Ganglion of foot, excision of	Daycare	
4125	Hallux valgus and follow up, other than simple removal of exostosis, unilateral operation for	1 Night Only	
4130	Hallux valgus and follow up, other than simple removal of exostosis, bilateral, operation for		
4135	Hammertoe, correction of , single toe	Daycare	5.04
4140	Hammertoe, bilateral, correction of	1 Night Only	
4145	Grice's operation, subtalar bone block		
4155	Avulsion of nail plate, partial or complete, simple	Side Room/ Outpatient, Service	5.28
4160	Excision of nail and nail matrix, partial or complete (e.g. ingrown or deformed nail), for permanent removal	Side Room/ Outpatient, Service	5.28
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	
4162	Tarsal tunnel release (posterior tibial nerve decompression)		
4170	Laprau's operation to correct position of toe		
4175	Metatarsal heads, excision of all, and plastic correction of sole, unilateral		
4180	Metatarsal heads, excision of all, and plastic correction of sole, bilateral, (Hoffman's)		
4181	Metatarsal joint replacement with prosthesis (IP)	I.P.	
4182	Metatarsal osteotomy, unilateral	Daycare	5.05
4183	Metatarsal osteotomies, bilateral	1 Night Only	
4184	Chevron osteotomy, single	1 Night Only	5.06
4185	Os calcis, osteotomy of (Dwyer)		
4190	Os calcis and bursa, posterior exostosis of, unilateral removal of		
4195	Os calcis and bursa, posterior exostosis of, bilateral, removal of		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
4215	Stamm's operation, unilateral		
4220	Stamm's operation, bilateral		
4225	Talectomy		
4230	Tarsal osteotomy		
4235	Tendon transplantation about the foot, multiple		
4240	Tendon transplantation about the foot, single		
4245	Tendon transplantation, flexor and extensor all toes, unilatera		
4250	Tendon transplantation, flexor and extensor all toes, bilateral		
4255	Trans metatarsal amputation of foot		
4260	Trans metatarsal amputation of one toe		
4261	Trans metatarsal amputation of two or more toes		
4200	Plantar fascia, excision or division of, unilateral	Daycare	
4205	Plantar fascia, excision or division of, bilateral		

Forearm and Elbow

3280	Amputation through forearm		
3285	Annular ligament, repair of		
3290	Anterior capsulotomy and excision (myositis ossificans)		
3295	Arthrodesis of elbow joint (I.P.)	I.P.	
3296	Arthroscopy, elbow, diagnostic, with or without synovial biopsy, removal of loose body or foreign body, synovectomy, debridement	Daycare, I.P.	
3297	Arthroscopy, elbow, surgical; includes extensive debridement to all parts of the elbow joint, with complete synovectomy (osteocapsular arthroplasty)(I.P.)		
3300	Arthroplasty (Forearm & Elbow) (I.P.)	I.P.	
3315	Drainage of elbow joint		
3316	External fixation, upper limb		
3320	Fracture forearm (complete), closed reduction and Plaster of Paris	Daycare	
3325	Fracture forearm (greenstick), closed reduction and Plaster of Paris		
3330	Fracture about elbow, closed manipulation of		
3335	Fracture dislocation, open reduction of (forearm/elbow)		
3340	Fracture of forearm bones, open reduction of		
3341	Open reduction, internal fixation and bone grafting (forearm/ elbow)		
3345	Fracture of lateral condyle, open reduction of		
3350	Fracture of medial condyle, open reduction of		
3355	Fracture (supracondylar), closed reduction of		
3360	Fracture, olecranon, screwing of		
3365	Closed treatment of elbow dislocation (I.P.)	I.P., Service	
3370	Nerve, ulnar, transplant		
3375	Olecranon bursa, removal of	Daycare	
3380	Radius, excision of head of		
3381	Silastic interposition of radial head		
3385	Open synovectomy of elbow joint		
3390	Tendon transplants about the elbow		
3395	Tendon sheaths, removal of, in forearm	Daycare	
3400	Tennis elbow, advancement of extensor muscles e	Daycar	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3406	Decompression fasciotomy, forearm and/or wrist flexor or extensor compartment; with or without debridement of non-viable muscle and/or nerve		

Hand

3035	Abscess or infected tendon sheath of palmar spaces, drainage of		
3039	Debridement/synovectomy of metacarpophalangeal and/or proximal interphalangeal joints, more than two joints		
3040	Arthrodesis of joint (I.P.)	I.P., Daycare	
3041	Arthrodesis of the carpometacarpal joint of the thumb using bone graft		
3045	Arthroplasty, using joint prosthesis, single (IP)	I.P.	
3050	Arthroplasty, using joint prosthesis, two joints (IP)	I.P.	
3055	Arthroplasty, using joint prosthesis, more than two joints(IP)	I.P.	
3070	Bursectomy		
3075	Benign bone tumours, multiple, excision of, with or without bone graft		
3080	Benign bone tumour, single, excision of, with or without bone graft		
3085	Exostosis, excision of	Daycare	
3095	Fracture of phalanges and/or metacarpals, closed reduction (I.P.)	I.P., Daycare	
3100	Fracture of phalanx, single, internal fixation	Daycare	
3105	Fracture of phalanges, multiple, internal fixation		
3106	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation when performed, for complex crush injuries requiring bone reconstruction		
3110	Ganglion or mucous cyst of hand, surgical removal of (includes repair)	Side Room, I.P.	
3115	Manipulation for treatment of dislocation of metacarpophalangeal joint (I.P.)	I.P., Side Room Service	
3120	Nail, removal of	Side Room/ Outpatient, Service, Histology to a limit of €655.28	5.28
3125	Nails, removal of all	Daycare	
3126	Debridement and repair of nail bed, for simple crush injuries	Side Room	
3135	Synovioma, excision of	Daycare	
3136	Tendon repair, flexor-double (hand)		
3140	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure (use also for traumatic amputations)		
3145	Amputation of two or more fingers		
3150	Trigger finger, correction of	Daycare	
3155	Whitlow, incision and drainage	Side Room/ Outpatient, Service	5.28
4061	Arthroscopy of metacarpophalangeal joint, with or without biopsy	I.P., 1 Night Only	
4062	Debridement/synovectomy of , metacarpophalangeal and/or proximal interphalangeal joint, one or two joints	I.P., 1 Night Only	
4063	Arthroscopic repair of displaced MCP ulnar collateral ligament (e.g. Stener lesion)	I.P.	

Hip and Femur

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3630	Acetabuloplasty, shelf operation		
3631	Internal fixation of acetabular fractures		
3635	Acute dislocation, manipulation for		
3636	Congenital dislocation of hip, E.U.A. and P.O.P. (I.P.)	I.P., Daycare	
3640	Acute dislocation or fracture dislocation, open reduction, hip/femur		
3645	Above knee amputation		
3650	Arthrodesis, hip/femur		
3654	Hip arthroscopy, with acetabuloplasty (i.e. treatment of pincer lesion) includes labral repair and loose body removal if performed I.P.,	1 Night Only	
3655	Arthroplasty of hip using prosthesis, bilateral (IP)	I.P.	
3656	Arthroscopy, hip, diagnostic; with or without synovial biopsy (separate procedure) (I.P.)	I.P., 1 Night Only	
3657	Arthroscopy, hip, surgical; with synovectomy (I.P.)	I.P., 1 Night Only	
3658	Hip arthroscopy, with femoroplasty (i.e. treatment of cam lesion) includes loose or foreign body removal if performed	1 Night Only	
3659	Hip arthroscopy, with removal of loose/foreign body, debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty and/or resection of labrum	I.P., 1 Night Only	
3660	Arthroplasty of hip using prosthesis, unilateral (IP)	I.P.	
3661	Revision of total hip arthroplasty, acetabular and femoral components with or without autograft or allograft (IP)	I.P.	
3665	Arthrotomy for loose body		
3666	Metal on metal hip resurfacing arthoplasty (unilateral) (IP)	I.P.	
3667	Metal on metal hip resurfacing arthoplasty (bilateral)(IP)	I.P.	
3675	Corrective osteotomy with or without internal fixation		
3680	Curetting of greater trochanter and bursectomy		
3690	Hind quarter amputation		
3695	Drainage of hip joint for acute infection (I.P.)	I.P.	
3700	Exostosis of femoral neck in slipped femoral epiphysis, excision of (for patients <18 years only)	I.P.	
3705	Femoral condyle, osteotomy of (I.P.)	I.P.	
3709	Fractured femur, hemiarthroplasty		
3710	Fractured shaft of femur, open reduction, with internal fixation		
3715	Fractured shaft of femur, closed reduction, with traction		
3720	Fractured femur (supracondylar) open reduction of		
3723	Fractured shaft of femur, closed intramedullary nailing		
3724	Fractured shaft of femur closed intramedullary, interlocking nail		
3725	Fracture of neck of femur, intramedullary nail fixation of		
3729	Repair, non union or malunion, femur, distal to head and neck with iliac or other autogenous bone graft (includes obtaining graft)		
3730	Fracture of femur (pertrochanteric or introchanteric) intramedullary nail fixation of		
3731	Open treatment of anterior ring fracture and/or dislocation with internal fixation, (includes pubic symphysis and/or rami)		
3732	Open treatment of posterior ring fracture and/or dislocation with internal fixation, (includes ilium, sacro-iliac joint and/or sacrum)		
3733	Pelvic fracture, external fixation		
3735	Hip deformity, soft tissue operations for correction of (I.P.)	I.P.	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3745	Manipulation of hip, closed, requiring general anaesthetic	Service, Daycare	
3750	Open reduction and/or rotation osteotomy		
3751	Open reduction, pelvic osteotomy and femoral shortening		
3755	Pelvic osteotomy		
3756	Modified innominate osteotomy including bone graft		
3760	Pseudoarthroplasty of hip (Girdlestone operation)		
3765	Slipped femoral epiphysis, intramedullary nail, fixation of		
3770	Slipped femoral epiphysis, lower end, stapling of		
3775	Synovectomy of hip joint and debridement	I.P.	
3785	Transplantation of psoas muscle to greater trochanter (Mustard's or Sherrard's operation)		

Humerus and Shoulder

3401	Arthroscopy, shoulder, surgical, with lysis and resection of adhesions, and/or removal of loose body or foreign body, and/or synovectomy or bursectomy, and/or debridement with or without manipulation (I.P.)	I.P.	
3402	Arthroscopic suture capsulorrhaphy for anterior shoulder instability		
3403	Arthroscopy, shoulder, diagnostic with or without synovial biopsy (I.P.)	I.P., Diagnostic, Daycare	
3404	Acromioplasty		
3405	Open acromio-clavicular joint, excision of		
3407	Arthroscopy, shoulder, surgical; repair of SLAP lesion (I.P.)	I.P.	
3408	Arthroscopy, shoulder, surgical; with rotator cuff repair (I.P.)	I.P., 1 Night Only	
3409	Shoulder replacement, total includes reverse total shoulder arthrosplasty	I.P.	
3410	Acromio-clavicular joint, open reduction of		
3411	Arthroscopic subacromial decompression , includes diagnostic arthroscopy (code 3403) (I.P.)	I.P., 1 Night Only	
3412	Arthroscopic excision outer end of clavicle		
3413	Arthroscopic excision outer end of clavicle/subacromial decompression, includes diagnostic arthroscopy (Code 3403)	I.P., 1 Night Only	
3414	Arthroscopy, Shoulder, Surgical; biceps tenodesis (I.P.)	I.P.	
3415	Amputation through arm		
3420	Arthrodesis, humerus/shoulder		
3430	Biopsy, synovial, humerus/shoulder	I.P., Diagnostic	
3435	Capsulotomy (acute capsulitis)		
3440	Disarticulation, humerus/shoulder		
3445	Dislocation, open reduction of, humerus/shoulder	I.P.	
3450	Dislocation, acute, manipulation under general anaesthetic, humerus/shoulder	Daycare	
3455	Dislocation, Open recurrent, operation for, humerus/shoulder		
3464	Forequarter amputation		
3465	Fractured clavicle, closed reduction of		
3470	Fractured clavicle, open reduction of		
3471	Open reduction internal fixation and bone grafting non union of a fracture of the clavicle		
3475	Fractured humerus, open reduction with internal fixation		
3480	Fractured humerus, open reduction and bone graft		
3485	Fractured humerus, closed reduction of		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3495	Manipulation of shoulder joint under general anaesthetic (I.P.)	I.P., Daycare, Service	
3500	Open repair of capsule (in rotator cuff injuries) humerus/shoulder (I.P.)	I.P.	
3510	Subacromial bursectomy	I.P.	
3515	Tendon transplant about shoulder		
5875	Shoulder replacement, hemiarthroplasty (humeral head prosthesis)	I.P.	
3416	Arthroscopy, shoulder, surgical; with rotator cuff repair and decompression of subacromial space by bursectomy and/or acromioplasty	I.P.	

Knee and Lower Leg

3790	Below knee amputation		
3795	Arthrodesis, knee		
3815	Baker's cyst, excision of	Daycare	
3816	Bone transportation		
3817	Removal of fixator device, tibia	Daycare	
3818	Arthroscopy of knee, surgical; with lateral release	Daycare	
3819	Arthroscopy, knee, diagnostic, with or without synovial biopsy	Diagnostic, Daycare, I.P.	
3820	Cartilage(s), removal of, knee	Daycare	
3821	Arthroscopy and removal of cartilage, knee, with meniscectomy (medial or lateral including meniscal shaving) including debridement / shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	Daycare, I.P.	5.07
3822	Arthroscopy of the knee for removal of loose body or foreign body, synovectomy, debridement (I.P.)	I.P., Daycare	
3825	Corrective osteotomy of tibia in region of knee		
3830	Corrective osteotomy of tibia in region of ankle		
3835	Cruciate ligaments, repair		
3836	Arthroscopic anterior cruciate ligament reconstruction	1 Night Only	
3837	Arthroscopic anterior cruciate ligament reconstruction and menisectomy	I.P., 1 Night Only	
3838	Arthroscopic anterior cruciate ligament reconstruction and menisceal repair	1 Night Only	
3839	Arthroscopy of knee with meniscus repair by suture fixation (medial and /or lateral)	Daycare	
3840	Drainage of joint in acute infection		
3845	Exploration of joint, knee/lower leg		
3850	Fixed flexion of knee, soft tissue operations for		
3855	Fracture dislocation of knee joint, operations for		
3860	Fracture of tibia (condylar) open reduction of		
3865	Fracture of tibial shaft, open reduction and internal fixation		
3870	Fracture of tibial shaft, closed reduction of		
3871	Fracture of tibial shaft, closed intra-medullary, interlocking nail		
3880	Lateral ligaments, repair		
3885	Manipulation under general anaesthetic, knee/lower leg (I.P.) I.P., Service		
3890	Osteochondritis dissecans, Smillies operation for		
3895	Patellectomy or open reduction of fractured patella		
3896	Resurfacing of patella		
3900	Pre patellar bursa, removal of Daycare		
3905	Plication of vastii, etc.		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3909	Prosthetic replacement (total) of knee joints, bilateral (IP)	I.P.	
3910	Prosthetic replacement (total) of knee joint, unilateral (IP)	I.P.	
3911	Revision of arthroplasty of knee joint, with or without allograft, one or more components (IP)	I.P.	
3912	Reconstruction of knee, (anterior cruciate)		
3915	Quadriceps mechanism, repair		
3920	Slipped epiphysis, stapling of, or epiphysiodesis		
3925	Slipped epiphysis (tibial and femoral combined), stapling of, or epiphysiodesis		
3930	Slipped epiphyses (bilateral tibial), stapling of		
3931	Slocum's or similar procedure		
3935	Synovectomy		
3940	Synovial biopsy, knee/lower leg	Diagnostic, Daycare	
3944	Reconstruction (advancement) posterior tibial tendon with excision of accessory tarsal navicular bone (eg Kidner type procedure)		
3945	Tendon transplants about knee joint		
3950	Transplant of tibial tubercle		
3951	Decompression fasciotomy, leg		
5890	Ligament reconstruction at the knee joint (I.P.)	I.P.	
5891	Ligament reconstruction of the knee joint using autogenous graft (I.P.)	I.P.	
3833	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion) medical or lateral) (I.P.)	I.P., 1 Night Only	
3834	Arthroscopy, knee, surgical; for infection, lavage and drainage (I.P.)	I.P.	
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.	
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.	
3874	Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation when performed (includes arthroscopy) (I.P.)	I.P.	
3876	Arthroscopically aided treatment fotibial fracture, proximal (plateau); bicondylar, includes internal fixation, when performed (includes arthroscopy) (I.P.)	I.P.	
3914	Patellofemoral arthroplasty of knee joint; condyle and plateau medial or lateral compartment (I.P.)	I.P	

Other

4263	Chemodenervation of muscle(s); extremity(ies) and/or trunk muscle(s) (e.g. for dystonia, cerebral palsy, multiple sclerosis)		
4264	Arthroscopy (not otherwise specified) (IP)	I.P., Diagnostic	
4265	Arthrotomy for removal of loose bodies	Daycare	
4271	Costotransversectomy		
4272	Excision of large malignant bone tumours for limb conservation		
4273	Excision of large malignant bone tumours for limb conservation including prosthetic insertion		
4275	Application of body cast (surgery benefit includes removal)	Daycare	
4280	Bone cysts (long bones only), excision		
4285	Bursectomy, large joints	Daycare	
4290	Chondroma, removal	Daycare	
4295	Exostosis of long bones, removal		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
4300	Fracture sternum and ribs, operative reduction		
4301	Limb lengthening (upper or lower limb) including osteotomy procedure and application of fixator devices		
4305	Partial excision of osteomyelitic bone (e.g. sequestrectomy, diaphysectomy), long bones, with or without bone grafting (not for bone biopsy)	I.P.	
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)		
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)		
4308	Adjustment or revision of (uniplane or multiplane) external fixation system requiring general anaesthetic		
4309	External fixation system (uniplane or multiplane as in procedure codes 4306 and 4307) removal under general anaesthetic	Daycare	
4310	Partial excision of osteomyelitic bone (e.g. saucerisation, craterisation), bones of foot, ankle (including malleoli), hand or wrist, with or without bone grafting (not for bone biopsy)	I.P.	
4320	Removal of plates, pins, screws; superficial (includes removal of sternum wire) (I.P)	I.P., Daycare	
4325	Removal of plates, pins, screws; deep dissection through muscle into bone requiring layered repair of incision (I.P)	I.P., Daycare	
4330	Trimming of stump following amputation of limb		
4332	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g. fingers, toes) (I.P.)	I.P., Side Room/ Outpatient, Service	5.28
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/ Outpatient, Service	5.28
4334	Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g. shoulder, hip, knee joint, subacromial bursa) (I.P.)	I.P., Side Room/ Outpatient, Service	5.28
4270	Biopsy of tumour of long bones, open Diagnostic		

Arthrocentesis / Injections

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	
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	
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	
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	
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	
5624	Injection, anaesthetic agent, intercostal nerve, single (I.P.)	I.P., Side Room	
5625	Injection, anaesthetic agent, intercostal nerve, multiple, regional block (I.P.)	I.P., Side Room	
3130	Application of Plaster of Paris casts as a separate procedure not associated with concurrent surgery (I.P.)	I.P., General Anaesthesia Day Care	
4331	Injection, tendon sheath, ligament, or ganglion cyst (I.P.)	I.P., Side Room Service	

Sacro Iliac Joint

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3605	Arthrodesis, sacro iliac joint (IP)	I.P.	
3610	Aspiration, sacro iliac joint	Service, Side Room	
3615	Biopsy of sacro iliac joint region	Diagnostic	
3620	Injection of sacro iliac joint region (I.P.)	I.P., Side Room, Service	
3625	Pelvic osteotomy bilateral in ectopia vesica		

Wrist

3159	Arthroscopy of the wrist	Diagnostic, Daycare, I.P.	
3160	Arthrodesis, using bone graft		
3165	Arthroplasty (I.P)	I.P.	
3175	Bone grafting operation on scaphoid		
3176	Herbert screw fixation, scaphoid		
3180	Carpal bone (lunate scaphoid trapezium), excision of		
3181	Trapezial joint replacement		
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	
3185	Carpal tunnel, decompression	Daycare, I.P.	
3190	Carpus or peri-carpal dislocations, manipulation		
3191	Endoscopy, wrist, surgical, with release of transverse carpal ligament	Daycare	
3192	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint	Daycare	
3195	Corrective osteotomy of lower end of radius		
3200	Dislocation of wrist, open reduction of		
3205	Fracture (Colles'), internal fixation of		
3210	Fracture (Colles'), manipulation and Plaster of Paris	Daycare	
3211	Fracture of distal radius, external fixation of		
3225	Ganglion, surgical removal of	Daycare	
3229	Intercarpal fusion		
3230	Nerve block for pain control, wrist joint	Service, Side Room	
3235	Nerve, median and ulnar nerve, repair of		
3240	Nerve, median or ulnar nerve, repair of		
3245	Radial styloid, excision of		
3250	Sympathetic block	Side Room	
3255	Synovectomy of wrist joint	Daycare	
3260	Tendon, repair at wrist, single		
3265	Tendons, repair at wrist, multiple		
3270	Tendon transfer about the wrist, single		
3271	Tendon transfer about the wrist, multiple		
3275	Ulna, lower end of (malunited Colles'), excision of		
3276	Smith's or Barton's fractures, internal fixation of		
3277	Manipulation of wrist under general anaesthetic (to gain loss of motion following a surgical procedure or due to scar tissue)	Daycare	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3161	Arthroscopy, wrist, surgical; for infection, lavage and drainage	I.P., 1 Night Only	
3162	Arthroscopy, wrist, surgical; synovectomy, partial (I.P.)	I.P., 1 Night Only	
3163	Arthroscopy, wrist, surgical; synovectomy, complete (I.P.)	I.P., 1 Night Only	
3164	Arthroscopy, wrist, surgical; excision and /or repair of triangular fibrocartilage and/or joint debridement (I.P.)	I.P., 1 Night Only	
3166	Arthroscopy, wrist, surgical; internal fixation for fracture or instability (I.P.)	I.P.	

Tendons

1410	Tendon repairs (primary), single		
1415	Tendon repairs (primary), multiple		
1420	Tendon sheath, incision of		
1425	Tenotomy	Daycare	
1426	Tenolysis	I.P., Daycare	

ORTHOPAEDIC OPERATIONS - PAYMENT RULES

5.01	This code cannot be charged in conjunction with code 4095, 4182, 4184
5.02	This code cannot be charged in conjunction with code 4090, 4182, 4184
5.03	This code cannot be charged in conjunction with code 4135
5.04	This code cannot be charged in conjunction with code 4110
5.05	This code cannot be charged in conjunction with code 4090, 4095, 4184
5.06	This code cannot be charged in conjunction with code 4090, 4095, 4182. Max 1 night hospital stay.
5.07	Cannot be charged in conjunction with Code 3839
5.28	Where these procedures are done in an Outpatient setting there is an enhanced surgeon fee. See Minor Procedure list.

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Gynaecological Operations

Cervix

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2140	Cervix, amputation of (I.P.)	I.P.	
2145	Cervix, biopsy of (I.P.)	I.P., Diagnostic, Side Room	
2146	Cervix, cone biopsy of (I.P.)	I.P., Diagnostic, Daycare	
2150	Cervical polypi, removal of (I.P.)	I.P., Side Room, Service	
2151	Knife cone biopsy of cervix I.P.	I.P., Diagnostic, Daycare	
2155	Cervix, dilatation of (I.P.)	I.P., Daycare	
2160	Cervix, local excision of lesion (I.P.)	I.P., Side Room	
2170	Cervix, suture of (I.P.)	I.P.	
2171	Cervical cerclage	I.P.	
2172	Cerclage of cervix, during pregnancy through abdominal incision	I.P.	
2175	Cervix, cautery of (I.P.)	I.P., Side Room	
2180	Cervix, examination when medically necessary to perform under anaesthesia (I.P.)	I.P., Diagnostic, Daycare	
2181	Colposcopy	I.P., Diagnostic, Side Room, Service	
2183	Colposcopy and diagnostic biopsy (I.P.)	I.P., Diagnostic, Side Room, Service	
2184	Colposcopy and therapeutic loop electrode biopsy(s) of the cervix (I.P.)	I.P., Side Room, Service	
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.)	I.P.	
2182	Colposcopy with Lletz procedure for lesion removal and/or laser therapy (I.P.)	I.P., Side Room, Service	

Foetal Medicine

2209	Chorionic villus sampling with ultrasound guidance	Diagnostic, Side Room	2.01, 2.02
2211	Amniocentesis, with ultrasound guidance	Diagnostic, Side Room	2.01, 2.02
2213	Foetal fluid drainage (e.g. vesicocentesis, thoracentesis, paracentesis), including ultrasound guidance, diagnostic or therapeutic (I.P.)	I.P.	2.02
2214	Transfusion, intrauterine, foetal, with ultrasound guidance, to treat confirmed foetal anaemia or thrombocytopaenia		2.02
2216	Advanced foetal ultrasound, real time with image documentation, detailed foetal and maternal anatomical examination, only payable following referral by the initial Obstetrician for a documented suspected abnormality identified by a prior ultrasound	I.P., Side Room, Diagnostic	2.02
2217	Fetoscopic surgery, using a fetoscope or shunt, and ultrasound guidance, to correct structural malformations		2.03
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	I.P., Side Room, Diagnostic	2.02

Obstetrical

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2190	Caesarean section (grant in aid for obstetrician's fees, only payable when the consultant obstetrician performs the procedure)		
2200	Ectopic pregnancy, surgical management (laparoscopic or open): salpingectomy and/or salpingo oophorectomy, unilateral or bilateral		
2206	Vaginal delivery (grant in aid), only payable when the consultant obstetrician is present for the delivery		
2207	Epidural anaesthesia for vaginal delivery		
2208	General anaesthetic for complications of full-term delivery requiring operative intervention in theatre		2.04
2185	Caesarean hysterectomy		

Uterus and Adnexa

2225	Dilatation and curettage (diagnostic or therapeutic) (I.P.)	I.P., Daycare	
2241	Surgical repair of extensive tubal and peritubal disease consequent on pelvic inflammatory disease or endometriosis, unilateral or bilateral		
2244	Hysteroscopy with sampling of endometrium and/or polypectomy, with or without dilatation and curettage, with removal of leiomyomata (I.P.)	I.P., Daycare	
2246	Hysteroscopy with insertion of intrauterine device for menorrhagia (not for contraceptive purposes)	I.P., Service, Side Room	
2247	Insertion of intrauterine device for menorrhagia, not for contraceptive purposes (I.P.)	I.P., Outpatient, Service	2.05
2248	Hysteroscopy	I.P., Side Room	
2249	Hysteroscopy, surgical; with complete endometrial resection or ablation for menorrhagia (I.P.)	I.P., Daycare	
2250	Total abdominal hysterectomy		
2251	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy with or without dilatation and curettage	I.P., Daycare	
2253	Total vaginal hysterectomy combined with sacrospinous ligament fixation of vagina and both anterior and posterior pelvic floor repair		
2255	Radical abdominal hysterectomy for malignancy, with bilateral total pelvic and/or para-aortic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without salpingooophorectomy, with or without removal of tube(s), with or without removal of ovary(s) including robotic approach.		
2256	Total vaginal hysterectomy combined with anterior and posterior pelvic floor repair		
2257	Total abdominal hysterectomy with unilateral or bilateral salpingo oophorectomy		
2258	Resection of ovarian malignancy with total abdominal hysterectomy, complete procedure including robotic approach.		
2259	Debulking of ovarian carcinoma with or without omentectomy, complete procedure including robotic approach		
2260	Sub total abdominal hysterectomy		
2264	Total vaginal hysterectomy with urethropexy or urethroplasty	I.P.	
2265	Total vaginal hysterectomy		
2267	Total vaginal hysterectomy and anterior or posterior pelvic floor repair	I.P.	
2268	Vaginal hysterectomy with bilateral salpingo-oophorectomy	I.P.	
2269	Total vaginal hysterectomy combined with sacrospinous ligament fixation of vagina and anterior or posterior pelvic floor repair	I.P.	
2280	Myomectomy (multiple) by abdominal incision (I.P.)	I.P.	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2280	Myomectomy (multiple) (I.P.) including robotic approach	I.P.	
2285	Myomectomy (single) by abdominal incision (I.P.)	I.P.	
2285	Myomectomy (simple, single) (I.P.) including robotic approach	I.P.	
2289	Oophorectomy, unilateral or bilateral (complete or partial) (I.P.)	I.P.	
2300	Ovarian cystectomy by abdominal approach, unilateral or bilateral (IP) (ref code 2487 or 2489 if procedure is performed laparoscopically)	I.P.	
2319	Salpingectomy complete or partial, unilateral or bilateral (I.P.)	I.P.	
2354	Salpingostomy or salpingolysis, abdominal incision, unilateral or bilateral (I.P.) (ref code 2487 or 2489 if procedure is performed laparoscopically)	I.P.	
2364	Microsurgical tuboplasty (salpingostomy or salpingolysis), unilateral or bilateral (I.P.) I.P.		
2365	Salpingo oophorectomy, complete or partial, unilateral or bilateral (I.P.) I.P.		
2370	Uterus, plastic reconstruction of Daycare		
2375	Ventrosuspension/Gilliam's operation (I.P.) I.P., Daycare		
2376	Hysterocontrast sonography (HyCoSy) Side Room		
2377	Endoscopic periurethral injection of bulking agents that are approved by FDA for urinary incontinence. Benefit is payable for a maximum of 3 treatments I.P.	I.P., Side Room	2.07
2281	Laparoscopy, Surgical, myomectomy (multiple) (I.P.)	I.P., 1 Night Only	
2286	Laparoscopy, surgical, myomectomy (single) (I.P.)	I.P., 1 Night Only	
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., 1 Night Only	
2235	Microsurgical repair of extensive tubal and peritubal disease consequent on pelvic inflammatory disease and endometriosis including re-implantation of fallopian tube, unilateral		
2240	Microsurgical repair of extensive tubal and peritubal disease consequent on pelvic inflammatory disease and endometriosis including re-implantation of fallopian tubes, bilateral		

Vulvovaginal

2380	Atresia vaginae, relief of (including dilatation of vulva and vagina) (I.P.)	I.P., Daycare	
2385	Bartholin's gland cyst, excision of	Daycare	
2395	Caruncle, vulvovaginal, removal of (I.P.)	I.P., Daycare	
2400	Colporrhaphy with amputation of cervix, anterior and posterior (Manchester or Fothergill operation)	I.P.	
2410	Colpotomy	Daycare	
2415	Cystocele, repair of (I.P.)	I.P.	
2420	Cystocele and rectocele, repair of (including colpoperineorraphy)		
2425	Cysts or simple tumours of the vulva or vagina, excision of	Daycare	
2426	Repair of enterocele, vaginal or abdominal approach (I.P.)	I.P.	
2430	Hymenotomy (I.P.)	I.P., Daycare	
2435	Hymenectomy	Daycare	
2440	Perineal tear, (excludes child birth and 1st of 2nd degree tears) complete, repair of (IP)	I.P.	
2441	Partial vaginectomy (I.P.)	I.P.	
2444	Retropubic urethropexy or vesicourethropexy (including colposuspension) (e.g. Burch, MMK)		
2445	Rectocele, repair of (I.P.)	I.P.	
2450	Abdomino-vaginal suspension of bladder neck for stress incontinence (e.g. Stamey, Raz)		
2461	Closure of rectovaginal fistula; vaginal or transanal approach (I.P.)	I.P.	
2462	Closure of rectovaginal fistula; abdominal approach with or without colostomy (I.P.)	I.P.	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2465	Vaginal fistulae (vesico vaginal), repair of		
2470	Vaginal wall, suture of non-obstetrical tear due to trauma		
2471	Sacrospinous ligament fixation for prolapse of vagina (I.P.)	I.P.	
2472	Colpopexy, intra- peritoneal approach (uterosacral, levator myorrhaphy)(I.P.)	I.P.	2.06
2473	Colpocleisis (Le Fort type)		
2474	Colpopexy, vaginal; extra - peritoneal approach (sacrospinous, ilioccygeus)(I.P.)	I.P.	2.06
2480	Vulvectomy, simple, without glands		
2483	Laparoscopy, surgical, vaginal hysterectomy, with or without removal of tube(s) and/or ovary(s) (I.P.) including robotic approach	I.P.	
2484	Diagnostic laparoscopy with or without biopsy, with or without tubal irrigation/insufflation (I.P.)	I.P., Daycare	
2485	Vulvectomy, radical, with glands		
2487	Laparoscopy with or without biopsy and one or more of the following procedures: excision of lesions of ovary(ies); (ovarian cystectomy), solid tumours (e.g. large endometriomas or dermoid) pelvic viscera or peritoneal surface; diathermy of endometriosis; division of adhesions; puncture of cysts. This procedure may or may not include tubal irrigation/insufflation (I.P.)	I.P., Daycare	
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	
2489	Laparoscopy with or without biopsy and one or more of the following procedures: excision of lesions of ovary(ies) (ovarian cystectomy), solid tumours (eg large endometrioma or dermoid); pelvic viscera or peritoneal surface; diathermy of endometriosis; division of adhesions; puncture of cysts; lymph nodes sampling(biopsy) single or multiple. This procedure also includes dilatation and curettage (diagnostic or therapeutic), with or without tubal irrigation/insufflation (I.P.) including robotic approach.	I.P., Daycare	
2411	Laparoscopy, surgical, sacrocolpopexy (I.P.)	I.P.	
2481	Laparoscopy, surgical, with total hysterectomy, with or without removal of tube(s) and/or ovary(s) (I.P.) including robotic approach	I.P.	
2482	Laparoscopic radical hysterectomy for malignancy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without salpingo-oophorectomy (I.P.)	I.P.	
2390	Bartholin's or Skene's gland, abscess of, incision and drainage (I.P.)		

GYNAECOLOGY OPERATIONS - PAYMENT RULES

2.01	Benefit under procedure codes 2209, 2211 and 2212 is payable for patients at high risk for foetal aneuploidy foetal anaemia or foetal thrombocytopaenia following one or more investigations: • Abnormal ultrasound findings • Abnormal pregnancy serum tests • Patients with Rhesus or Kell sensitisation • Prior history of foetal abnormalities • Symptoms or signs suggestive of intrauterine infection
2.02	Benefit under procedure codes 2209, 2211, 2212, 2213, 2214, 2216 and 2218 is payable where the procedure is performed by a Consultant Obstetrician following referral from the attending Consultant
2.03	Benefit for procedure 2217 is payable where the procedure is performed by a Consultant Obstetrician following referral from the attending Consultant for the following indications: • In-utero repair of urinary tract obstruction • In-utero repair of congenital cystic adenomatoid malformation • In-utero repair of extralobar pulmonary sequestration • In-utero repair of sacrococcygeal teratoma • Fetoscopic laser therapy for treatment of twin-twin transfusion syndrome
2.04	Benefit for procedure code 2208 is payable when one of the following complications of full term delivery arise • Retained placenta with or without suturing of perineum • Vulval haematoma at the time of delivery • Primary or secondary post-partum haemorrhage
2.05	For procedure code 2247, benefit is only payable following a previous claim for hysteroscopy (code 2244, 2248 or 2251)
2.06	Where procedure code 2472 or 2474 is carried out at the same time as a hysterectomy, code 2267 will apply
2.07	Benefit is payable for a maximum of 3 Treatments

19

General Surgery

Abdominal Wall and Peritoneum

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5	Abdominal wall, secondary suture of		
15	Adhesions, division of by laparotomy or laparoscopy (I.P.)	I.P.	
20	Intra-abdominal injury with rupture of viscus, repair of (not including intraoperative injury) (I.P.)	I.P.	
25	Intra abdominal injury, multiple complicated with rupture of viscus (I.P.)	I.P.	
30	Laparotomy (I.P.)	I.P.	
35	Laparoscopy with or without biopsy (I.P.)	I.P., 1 Night Only	
45	Omentopexy		
50	Paracentesis abdominis		
60	Pelvic abscess, drainage of		
80	Peritoneum, drainage of (I.P.)	I.P.	
90	Laparotomy, intra-abdominal sepsis (I.P.)	I.P.	
5835	Peritoneal, venous shunt for ascites		

Adrenal Glands

95	Adrenalectomy, unilateral (I.P.)	I.P.	
101	Adrenalectomy for phaeochromocytoma		
102	Laparoscopy, surgical with adrenalectomy, partial or complete or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal		
106	Neuroblastoma, tru-cut biopsy	Diagnostic	
107	Neuroblastoma, resection		

Appendix

110	Appendicectomy (with or without complications) (I.P.)	I.P.	
111	Appendicectomy, laparoscopic approach (with or without complications) (I.P.)	I.P.	

Breast

1190	Abscess, incision and drainage of	Service, Side Room	
1191	Breast cyst(s) aspiration/fine needle biopsy (diagnostic or therapeutic) (I.P.)	I.P., Side Room/ Outpatient, Service	1.28
1195	Percutaneous core needle biopsy of breast with or without ultrasound guidance (I.P.) (for fine needle biopsy use procedure code 1191)	I.P., Side Room, Diagnostic, Service	
1198	Re-excision of margins arising from previous breast surgery (I.P.)	I.P., Daycare	
1200	Cysts or tumours, excision of, or lumpectomy, segmental resection, quadrant mastectomy or partial mastectomy	Daycare	
1205	Duct papilloma, excision of	Daycare	
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	1 Night Only	
1207	Skin sparing mastectomy with free skin and/or muscle flap with microvascular anastomosis (IP)	I.P.	
1208	Open periprosthetic capsulotomy breast (I.P.)	I.P.	
1209	Periprosthetic capsulotomy breast (I.P.)	I.P.	
1210	Gynaecomastia (excision for), unilateral.	Daycare, Pre-Auth	1.02

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1211	Gynaecomastia (excision for), bilateral.	Pre-Auth	1.02
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)	I.P.	
1213	Mastectomy, partial,with or without guidance with axillary clearance, or removal of sentinel node(s) (I.P)	I.P., 1 Night Only	
1214	Mastectomy, partial, guided excision, for ductal carcinoma insitu (I.P)	I.P., 1 Night Only	
1216	Mastectomy radical/ modified radical, with axillary clearance (IP)	I.P.	
1218	Mammographic wire guided excision breast biopsy	Diagnostic, Daycare	
1219	Mastectomy and axillary clearance, immediate breast reconstruction with latissimus dorsi pedicle flap, with or without prosthetic implant or expanding prosthesis (I.P.)	I.P.	
1221	Mastectomy and axillary clearance, immediate breast reconstruction with extended latissimus dorsi pedicle flap (IP)	I.P.	
1222	Mastectomy, complete with or without removal of sentinel node(s) with immediate insertion of tissue expander, includes subsequent expansions (I.P.)	I.P.	
1223	Mastectomy, partial, guided excision, with axillary sampling or removal of sentinel node(s), withvimmediate deep rotation flap reconstruction, with prosthetic implant		

Dialysis

822	Creation of permanent shunt for haemodialysis access, involving dissection of vessel/tunnelling, insertion of graft, suturing to vein and artery		
823	Home based haemodialysis, self dialysis training (max. 18 sessions)		
824	Management of chronic haemodialysis, in the patient's home or at a hospital outpatient department (minimum of three dialysis sessions per week, inclusive of all Consultant care), Monthly benefit		
825	Evaluation of a new patient initiating intermittent haemodialysis during a hospital admission, includes insertion of dialysis catheter, and the initial dialysis session (once only per member, use procedure code 826 for subsequent dialysis during same admission)		1.15
826	Intermittent haemodialysis subsequent to procedure code 825, during the same hospital admission, per session		
828	Intermittent haemodialysis during a subsequent hospital admission, of one night or more, necessitated by an intercurrent illness, per session		
830	Evaluation of a new patient initiating peritoneal dialysis during a hospital admission, includes insertion of temporary intraperitoneal catheter, and the initial dialysis session (once only per member, use procedure code 831 for subsequent in-patient exchanges)		1.16
831	For each subsequent peritoneal dialysis exchange during an overnight hospital stay		
833	Management of chronic peritoneal dialysis, in the patient's home or at a hospital out-patient department (inclusive of all Consultant care), Monthly benefit		
834	Insertion of tunnelled intraperitoneal catheter for dialysis, permanent		1.03
837	Continuous veno-venous haemofiltration or dialysis (CVVH/CVVHD) in a critically ill patient, per day		
841	Removal of permanent shunt for haemodialysis access (not for the removal of dialysis catheter)	Daycare	
838	Removal of tunnelled intraperitoneal catheter		

Gall Bladder & Bile Ducts

115	Cholecystojejunostomy		
116	Choledochojejunostomy (Roux - En - Y)		
117	Choledochoduodenostomy		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
118	Surgical repair of post-operative biliary stricture		
129	Hepaticojejunostomy		
132	Cholecystectomy with exploration of common bile duct		
134	Laparoscopic cholecystectomy including per-operative cholangiogram	1 Night Only	
135	Cholecystectomy including per operative cholangiogram		
136	Percutaneous removal of gallstones from the bile ducts		
140	Cholecystostomy with exploration, drainage or removal of calculus		
145	Hepaticoduodenostomy		
150	Transduodenal sphincteroplasty with or without transduodenal extraction of calculus		
151	Transhepatic insertion of biliary endoprosthesis or catheter for biliary drainage		
156	Revision and/or reinsertion of transhepatic stent (IP)	I.P.	
157	Change of percutaneous tube or drainage catheter, includes radiological guidance	Side Room, MAC	
612	Portoenterostomy (e.g. Kasai procedure)		

Gastric

155	Antrectomy and drainage		
165	Duodenal diverticula, excision of		
174	Wedge gastric excision for ulcer or tumour of stomach		
175	Gastrectomy, total or revision with anastomosis, pouch formation / reconstruction/Roux-en-Y reconstruction		
178	Gastric restrictive procedure with gastric by-pass for morbid obesity with Roux-En-Y gastroenterostomy (IP).	Pre-Auth, I.P.	1.04
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-Auth.	1.04
180	Gastrectomy, partial with anastomosis, pouch formation/ reconstruction/Roux-en-Y reconstruction (Not Claimable for Morbid Obesity)		
181	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (I.P.)	Pre-Auth, I.P.	1.04
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-Auth	1.04
183	Laparoscopy, surgical, longitudinal gastrectomy (i.e. Gastric Sleeve)	Pre-Auth, I.P.	1.04
190	Gastroenterostomy		
191	General anaesthesia for gastroscopy procedures (codes 192, 194, 198 or 206) and colonoscopy procedures (codes 450, 455, 456, 457, 458, 459, 530, 535 or 536) in children under 16 years of age		
192	Capsule Endoscopy	Diagnostic, Side Room, MAC	1.05
194	Upper G.I. endoscopy with or without biopsies (includes jejunal biopsy), with or without polypectomy.	Diagnostic, Side Room, MAC	1.06
198	Upper gastrointesinal endoscopy including oesophagus, stomach and either the duodenum and/or jenjunum as appropriate, with endoscopic ultrasound examination (IP)	Diagnostic, Side Room, MAC	1.07
200	Gastrostomy		
201	Insertion of percutaneous endoscopic gastrostomy (PEG) tube		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
202	Upper gastrointestinal endoscopy with endoscopic ultrasound exam including oesophagus, stomach and either the duodenum and/or jejunum as appropriate with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) of lymph nodes in oesophageal, gastric and lung cancer, biopsy of pancreatic lesion(s), mediastinal mass or submucosal lesion(s), with or without coeliac plexus neurolysis for pain arising from pancreatic cancer or chronic pancreatitis	I.P., Diagnostic, Side Room	
203	Upper gastrointestinal endoscopy with transendoscopic stent placement (includes pre and post dilation) in patients with obstructing lesions or strictures		
204	Gastric antral vascular ectasia, endoscopic argon plasma photocoagulation of	Side Room, MAC	
205	Gastrotomy/duodenotomy for haemorrhage		
206	Upper G.I. endoscopy with endoscopic mucosal resection	Diagnostic, Side Room, MAC	1.06
215	Over sewing perforated peptic ulcer		
230	Ramstedt's operation		
235	Stomach transection		
2062	Oesophagoscopy, rigid under general anaesthesia, with or with out biopsy, with or with out dilatation (IP)	I.P., Diagnostic, Daycare	
2063	Oesophagoscopy with radiofrequency ablation of Barrett's oesophagus with high grade dysplasia		
2070	Oesophagoscopy with removal of foreign body (I.P.)	I.P.	
2074	Upper G.I. endoscopy with oesophageal dilatation and laser therapy	Daycare	
2079	Oesophagoscopy with multiple injection or banding of oesophageal varices	1 Night Only	
2081	Balloon dilatation of the oesophagus (includes endoscopy)	Side Room	
5840	Oesphageal motility (manometric) studies with or without 24 hour pH recording	Diagnostic, Side Room	

Head & Neck

1041	Excision of Carotid body tumour greater than 4 cms		
1042	Excision of Carotid body tumour less than 4 cms		
1055	Cyst or benign tumour on lip, excision of (I.P.)	I.P., Side Room, Service	
1058	Epithelioma of lip, lip shave	Side Room	
1059	Epithelioma of lip, wedge excision	Daycare	
1106	Partial maxillectomy including plastic reconstruction		
1107	Total maxillectomy including plastic reconstruction		
1046	Excision of lesion of mucosa and submucosa, vestibule of mouth, with simple repair (I.P.)	I.P., Side Room	1.08
1047	Excision of lesion of mucosa and submucosa, vestibule of mouth, complex, with or without excision of underlying muscle (I.P.)	I.P., Daycare	1.08
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.)	I.P.	1.08
1065	Branchial cyst, pouch or fistula, excision of		
1075	Cysts or tuberculosis glands of neck (deep to deep fascia) excision of	Daycare	
1080	Conservative neck dissection		
1082	Radical neck dissection		
1085	Thyroglossal cyst or fistula, excision of		
1090	Torticollis, partial excision, open correction of		
1095	Tuberculous caseous glands or sinuses, curettage of		
1096	Oesophageal anastomosis, (repair and short circuit)		
1097	Partial Oesophagectomy		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
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)		
1100	Laceration of palate, repair of		
1104	Biopsy lesion of palate	Side Room	
1105	Radical operation for malignant growth of palate		

Hernia

241	Laparoscopic, surgical repair, epigastric/ventral hernia, (includes mesh insertion) initial or recurrent (I.P.)	I.P.	
243	Laparoscopic surgical repair, epigastric / ventral hernia (initial or recurrent) I.P.	I.P., 1 Night Only	
244	Laparoscopic surgical repair, epigastric / ventral hernia; incarcerated or strangulated I.P.	I.P.	
245	Epigastric/Ventral hernia, repair of (I.P.)	I.P., 1 Night Only	
246	Exomphalos, minor		
247	Exomphalos, major		
248	Exomphalos, delayed		
249	Laparoscopic, surgical repair, epigastric/ventral hernia, (includes mesh insertion) incarcerated or strangulated (I.P.)	I.P.	
250	Femoral hernia, repair of, bilateral		
255	Femoral hernia, repair of, unilateral (I.P.)	I.P., 1 Night Only	
270	Hiatus hernia, abdominal repair of		
271	Laparoscopic repair of hiatus hernia		1.10
275	Hiatus hernia, transthoracic, repair of (I.P.)	I.P.	
276	Laparoscopic surgical repair of incisional hernia (includes mesh insertion) (initial or recurrent) (I.P.)	I.P.	
277	Laparoscopic surgical repair of incisional hernia (includes mesh insertion)); incarcerated or strangulated (I.P.)	I.P.	
278	Laparoscopic surgical repair of incisional hernia: initial or recurrent I.P.	I.P.	
279	Laparoscopic surgical repair of incisional hernia : incarcerated or strangulated I.P.	I.P.	
280	Incisional hernia, repair of (I.P.)	I.P.	
283	Inguinal hernia, neonate up to six weeks of age, laparoscopic repair of, unilateral (I.P.)	I.P.	
284	Inguinal hernia, laparoscopic repair of, bilateral (I.P.)	I.P., 1 Night Only	
285	Inguinal hernia, repair of, bilateral (I.P.)	I.P., 1 Night Only	
286	Inguinal hernia, neonate up to six weeks of age, laparoscopic repair of, bilateral (I.P.)	I.P.	
287	Inguinal hernia, laparoscopic repair of, unilateral (I.P.)	I.P., 1 Night Only	
288	Strangulated inguinal hernia, laparoscopic repair of, unilateral (I.P.)	I.P.	
289	Repair of inguinal hernia, neonate up to six weeks of age, bilateral (I.P.)	I.P.	
290	Inguinal hernia, repair of, unilateral (I.P.)	I.P., 1 Night Only	
291	Strangulated inguinal hernia, unilateral (I.P.)	I.P.	
292	Repair of inguinal hernia, neonate up to six weeks of age, unilateral (I.P.)	I.P.	
295	Patent urachus, closure and repair of abdominal muscles		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
305	Recurrent hernia, repair of (I.P.)	I.P., 1 Night Only	
310	Umbilical hernia, repair of (I.P.)	I.P., 1 Night Only	

Jejunum & Ileum

320	Congenital defects, correction of (including Meckel's diverticulum)		
331	Gastroschisis		
355	Ileostomy or laparoscopic loop illeostomy(I.P.)	I.P.	
356	Ileoscopy, through stoma, with or without biopsy	Diagnostic, Side Room, MAC	
360	Resection of small intestine; single resection and anastamosis		
361	Intestinal atresia, single/multiple		
362	Intestinal stricturalplasty (enterotomy & enterorrahaphy) with or without dilation, for intestinal obstruction		
363	Intestinal stricturoplasty (enterotomy & enterorrahaphy) with or without dilation, for intestinal obstruction, multiple, 3 or more		
364	Hydrostatic reduction of intussusception		
370	Jejunostomy		
384	Laparoscopic resection and anastamosis of jejunum or ileum		
385	Resection and anastomosis of jejunum or ileum		
386	Surgical reduction of intussusception including repair with or without appendicectomy		

Large Intestine

389	Anal canal EUA (I.P.)	I.P., Daycare	
390	Anal canal, plastic repair of (for incontinence)		
391	Laparoscopic, low anterior/abdomino-perineal resection with colo-anal anastamosis		
392	Laparoscopic, mid/high anterior resection with colo-anal anastamosis		
395	Anal fissure, dilatation of anus (I.P.)	I.P., Daycare	
396	Anoplasty for low anorectal anomaly		
397	Anorectal anomaly, (posterior sagittal anorectoplasty PSARP), for high/intermediate anorectal anomaly		
400	Lateral internal sphincterotomy (I.P.)	I.P., Daycare	
401	Botulinum toxin injection of anal sphincter under general anaesthetic	Daycare	
404	Parks' anal sphincter repair		
410	Anus, excision of epithelioma of, with colostomy	Daycare	
415	Anus, excision of epithelioma of, without colostomy	Daycare	
420	Caecostomy (I.P.)	I.P.	
425	Caecostomy or colostomy, closure of		
430	Colectomy, partial		
431	Laparoscopic colectomy, partial		
432	Laparoscopic colectomy, total		
433	Laparoscopic colectomy, total with ileal pouch reconstruction		
434	Laparoscopic surgical closure of enterostomy, large or small intestine, with resection and anastomosis		
435	Colectomy, total		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
436	Total colectomy and ileal pouch construction with temporary ileostomy		
437	Closure of ileostomy		
438	Total colectomy for toxic megacolon		
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		
448	Double balloon enteroscopy (antegrade or retrograde) (see note below)	Daycare, Diagnostic, Service, MAC	1.11
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	Daycare	
450	Colonoscopy, left side	Diagnostic, Side Room, Service, MAC	1.12
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)	Service,Side Room, MAC	1.12
455	Colonoscopy, full colon	Daycare, Diagnostic, Service, MAC	1.12
456	Colonoscopy, left side, plus polypectomy	Service, Side Room, MAC	1.12
457	Colonoscopy plus polypectomy, full colon	Daycare, Diagnostic, Service, MAC	1.12
458	Left colonoscopy and laser photocoagulation of rectum	Side Room, MAC	
459	Colonoscopy, full colon and laser photocoagulation of rectum	Daycare, MAC	
460	Colostomy (I.P.)	I.P.	
461	Reduction of prolapsed colostomy stoma		
465	Resection of bowel and colostomy or anastomosis for diverticulitis		
466	Endoscopic transanal resection of large (>2cm) villous adenomas/ malignant tumours of rectum (ETART), using resectoscope		
467	Colonoscopy with transendoscopic stent placement (includes pre dilation)		
468	Excision of rectal tumour, transanal approach		
470	Faecal fistula, closure or resection		
485	Anal fistulotomy	I.P., Daycare	
486	Fistula-in-ano, excision with endo-anal flap and advancement (I.P.)	I.P.	
487	Fistula-in-ano, insertion/change of seton (I.P.)	I.P., Daycare	
488	Ano-rectal manometry	Diagnostic, Side Room	
490	Haemorrhoidectomy (external) (I.P.)	I.P., Daycare	
495	Haemorrhoidectomy, external, multiple (I.P.)	I.P., Daycare	
500	Haemorrhoidectomy (internal) includes exploration of anal canal (I.P.)	I.P.	
501	Haemorrhoidopexy (e.g. for prolapsing internal haemorrhoids) by stapling	1 Night Only	
506	Haemorrhoids, injection and/or banding (I.P.)	I.P., Side Room	
513	Meconium ileus, open reduction with or without stoma		
514	Meconium ileus reduction		
515	Imperforate anus, simple incision		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
516	Necrotising enterocolitis, percutaneous drainage		
517	Necrotising enterocolitis, laparotomy resection/stoma		
518	Panproctocolectomy		
520	Imperforate anus, with colostomy or pull through operation		
525	Ischio rectal abscess, incision and drainage (I.P.)	I.P., 1 Night Only	
530	Proctoscopy or sigmoidoscopy (I.P.)	I.P., Side Room, Diagnostic, Service, MAC	1.12
535	Proctoscopy or sigmoidoscopy, with biopsy	Diagnostic, Side Room, MAC	1.12
536	Diagnostic flexible sigmoidoscopy and biopsies	Sideroom, Diagnostic, MAC	1.12
540	Proctoscopy or sigmoidoscopy with biopsy of muscle coats of bowel, for megacolon	Daycare, Diagnostic	1.12
545	Prolapse of rectum, abdominal approach involving laparotomy, colostomy or intestinal anastomosis including laparoscopic approach		
549	Delorme procedure		
550	Prolapse of rectum, perineal repair (I.P.)	I.P.	
555	Closure of rectovesical fistula, with or without colostomy (I.P.)	I.P.	
556	Balloon dilation of the rectum	Daycare	
560	Rectal or sigmoid polypi (removal by diathermy etc.)	Daycare	
565	Rectum, excision of (all forms including perineoabdominal, perineal anterior resection and laparoscopic approach)		
570	Rectum, partial excision of		
574	Presacral teratoma, excision of		
576	Revision/refashioning of ileostomy and duodenostomy, complicated reconstruction in-depth (I.P.)	I.P.	
577	Low anterior resection with colo-anal anastomosis for cancer		
578	Soave procedure		
579	Internal sphincter myomectomy in children with Hirschsprung disease		
581	Sigmoidoscopy including dilatation of intestinal strictures	Daycare	
582	Proctectomy for recurrent rectal cancer in a radiated and previously operated pelvis		
585	Stricture of rectum (dilation of) (I.P.)	I.P., Daycare	
590	Volvulus (stomach, small bowel or colon, including resection and anastomosis)		
591	Correction of malrotation by lysis of duodenal bands and/or resection of midgut volvulus (e.g. Ladd procedure)		
5793	Percutaneous implantation of neurostimulator pulse generator and electrodes: faecal incontinence: trial stage	Pre- Auth, 1 Night Only	
5794	Percutaneous implantation of neurostimulator electrodes for faecal incontinence; permanent implantation	2 Nights Only	

Liver

595	Hepatotomy for drainage of abscess or cyst, one or two stages		
600	Biopsy of liver (by laparotomy) (I.P.)	I.P., Diagnostic	
601	Transjugular liver biopsy	Diagnostic	
605	Biopsy of liver (needle)	Diagnostic, 1 Night Only	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
608	Management of liver haemorrhage; simple suture of liver wound or injury		
611	Major liver resection	I.P.	
616	Wedge resection of liver		
617	Intrahepatic cholangioenteric anastomosis		
618	Resection of hilar bile duct tumour	I.P.	
619	Management of liver haemorrhage; exploration of hepatic wound, extensive debridement, coagulation and/or suture, with or without packing of liver		
622	Insertion of hepatic artery catheter and reservoir pump		
625	Liver, left lateral lobectomy		
626	Intra-operative radiofrequency ablation of liver metastases		
630	Excision of hydatid cyst		

Lymphatics

1310	Open superficial lymph node biopsy	Daycare	
1311	Biopsy or excision of lymph node(s); by needle, superficial (e.g. cervical, inguinal, axillary)	Side Room	
1314	Sentinel node biopsy with injection of dye and identification	Daycare	
1315	Axillary lymph nodes, complete dissection of		
1320	Axillary or inguinal lymph nodes, incision of abscess	Service, Side Room	
1326	Biopsy or excision of lymph node(s); open, deep cervical or axilliary node(s)	Diagnostic, Daycare	
1335	Inguinal or pelvic lymph node block dissection, unilateral (I.P.)	I.P.	
1336	Inguinal or pelvic lymph node block dissection, bilateral (I.P.)	I.P.	
1365	Primary or secondary retroperitoneal, lymphadenectomy complete, transabdominal (I.P.)	I.P.	

Muscle

1380	Muscle, repair and suture of		
1385	Muscle biopsy	Diagnostic, Side Room	

Nerve

1390	Nerve biopsy	Diagnostic	
1395	Nerve repairs (primary) (I.P.)	I.P.	
1400	Nerve suture (secondary, including grafting and anastomosis)		
1406	Neuroma, excision of	Daycare	
1407	Neurectomy		

Pancreas

771	ERCP sphincterotomy and extraction of stones		
772	ERCP sphincterotomy and insertion of endoprosthesis		
773	Biopsy of pancreas, percutaneous needle, includes radiological or ultrasound guidance		
774	ERCP (endoscopic retrograde cholangiogram of pancreas)	Diagnostic	
775	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple - type procedure); with pancreatojejunostomy		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
776	Pancreatic biopsy	Diagnostic	
778	Pancreaticojejunostomy		
779	ERCP ampullectomy with insertion of endoprosthesis		
780	Distal pancreatectomy including splenectomy		
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	
782	ERCP with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method		
785	Total pancreatectomy, distal, with gastrectomy, splenectomy, duodenectomy, cholecystectomy and resection of distal bile duct		
786	Simultaneous pancreas/kidney transplant		
790	Open surgical drainage of pancreatic abscess or pseudocyst		
795	Pancreatotomy for drainage of pancreatitis, abscess or cyst with exploration of biliary and pancreatic duct		

Parathyroid Glands

1110	Parathyroid adenoma, excision of		
1111	Transcatheter ablation of function of parathyroid glands		
1112	Parathyroid hyperplasia, excision of (4 glands, frozen section)		
1113	Total parathyroidectomy with auto transplant or mediastinal exploration/intra-thoracic		
1114	Parathyroid re-exploration		

Salivary Glands

1115	Abscess of salivary gland, incision and drainage		
1120	Fistula of salivary duct, repair of		
1125	Parotid or submandibular duct, dilatation of		
1126	Submandibular duct, relocation	I.P.	
1133	Excision of parotid tumour or parotid gland, lateral lobe, (superficial parotidectomy) with dissection and preservation of facial nerve	I.P.	
1134	Excision of parotid tumour or parotid gland, total, en bloc removal with sacrifice of facial nerve		
1135	Excision of parotid tumour or parotid gland, total with dissection and preservation of facial nerve		
1136	Excision of parotid tumour or parotid gland, lateral lobe, without nerve dissection		
1140	Salivary calculus, removal of	Daycare	
1141	Sialendoscopy with sialolithiasis, any method; complicated intraoral (I.P)	I.P., 1 Night Only	
1150	Submandibular salivary gland, excision of		
1151	Excision of sublingual gland		

Spleen

800	Splenectomy (I.P.), open or laparoscopic	I.P.	
806	Transcatheter ablation of function of spleen		
807	Aspiration of splenic cysts		

Thyroid Gland

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1152	Thyroid cyst(s) aspiration/fine needle biopsy (I.P.)	I.P., Side Room	
1154	Excision of thyroid cyst		
1155	Total/revision thyroidectomy	I.P.	
1156	Percutaneous core needle biopsy of thyroid gland (I.P.) (for fine needle biopsy use procedure code 1152)	I.P., Side Room, Diagnostic	
1157	Partial/subtotal thyroidectomy		

Tongue

1165	Excision of epithelioma of tongue with radical operation on glands		
1170	Frenectomy (tongue tie)	Daycare	
1174	Glossectomy; less than one-half tongue		
1175	Hemiglossectomy		
1176	Total glossectomy		
1180	Growths of tongue, diathermy to	Side Room	
1185	Excision biopsy, oral cavity (I.P.)	I.P., Side Room	
1186	Resection of tonsil, tongue base, palate, mandible and radical neck dissection		

GENERAL SURGERY - PAYMENT RULES

1.02	Clinical Indications for procedure codes 1210, 1211 are as follows: must be included on claim form for payment Benefit for excision of gynaecomastia in accordance with procedure codes 1210 and 1211 is subject to pre-certification. Gynaecomastia is defined as benign glandular breast enlargement due to ductal proliferation, stromal proliferation or both. The diagnosis must be based on both physical examination that confirms that the breast enlargement is true gynaecomastia and not pseudogynaecomastia, and laboratory, and other appropriate investigations as required should have been performed to identify any underlying reversible causes. In addition, the following conditions of payment must be satisfied in full; • Male >/=18 years • Post- pubertal • BMI <25 • Unilateral or bilateral gynaecomastia grade III or IV. (Grade III gynaecomastia being moderate breast enlargement exceeding the areola boundaries with edges that are distinct from the chest with skin redundancy. Grade IV being gynaecomastia being marked breast enlargement with skin redundancy and feminisation of the breast). • Gynaecomastia that has been present for at least 1 year and has persisted despite treatment for at least 4 months for the underlying pathological cause. • >/= 6 months pain or discomfort, directly attributable to breast hypertrophy, that is unresolved despite the continuous use for at least 4 weeks of prescription analgesia or non-steroidal anti-inflammatory drugs and significantly impacts on activities of daily living
1.03	Refer to procedure 838 for the removal of permanent intraperitoneal cannula catheter for drainage for dialysis (not for the removal of Hickman, Broviac, Vascath, or similar)
1.04	Clinical Indications for procedure codes 178, 179, 181, 182, 183 are as follows: must be included on claim form for payment 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 subject to pre-certification. 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, 182 and 183 are as follows • Benefit is restricted to those patients whose BMI is currently and has been for at least 2 years – greater than 40 or – greater than 40 and less than or equal to 50 and who have also been diagnosed with any of the following severe comorbidities: Coronary Heart Disease: Type 2 Diabetes mellitus : Clinically significant obstructive sleep apnoea or : Medically refractive hypertension (blood pressure greater than 140mmHg systolic and/or 90mmHg diastolic despite optimal medical management). In addition the patients must also satisfy all the criteria in No's 2 to 8. • Bariatric surgery is only payable in hospitals listed in the Irish Life Health directory of Hospitals and where Irish Life Health has approved the multi-disciplinary programme for the treatment of obesity. The multi disciplinary team must consist of a Consultant recognised by Irish Life Health 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. • 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. • 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. • 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 Irish Life Health. Individuals should generally be fit for anaesthesia and for surgery and understand the need for long term follow up. • The operation should be performed by a Consultant Surgeon with experience in bariatric surgery registered with Irish Life Health 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. • 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 Consultant 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. • Life long medical surveillance after surgical therapy is a necessity.

1.05	Clinical Indications for procedure code 192 are as follows: must be included on claim form for payment • For evaluation of loco-regional carcinoid tumours of the small bowel in persons with carcinoid syndrome; or • For initial diagnosis in persons with suspected Crohn's disease (abdominal pain or diarrhoea plus one or more signs of inflammation (fever, elevated white blood cell count, elevated erythrocyte sedimentation rate, or bleeding) without evidence of disease on conventional diagnostic tests, including small-bowel follow-through or abdominal CT scan/CT enterography and upper and lower endoscopy or • For investigation of patients with objective evidence of recurrent, obscure gastro intestinal bleeding (e.g. iron deficiency anaemia and positive faecal occult blood test, or visible bleeding) who have had upper and lower gastrointestinal endoscopies within the last 12 months that have failed to identify a bleeding source; or • For surveillance of small intestinal tumours in persons with Lynch syndrome, Peutz-Jeghers syndrome and other polyposis syndromes affecting the small bowel.
1.06	Clinical Indications for Endoscopy Procedures - must be included on claim form for payment **Upper G.I. Endoscopy** Clinical Indications for an upper G.I. endoscopy (excludes repeat procedures within 12 months, for which there are other specific clinical indications): Procedure code 194 is not payable in conjunction with procedure codes 198, 202 or 271 **Ind. Code** • Upper abdominal symptoms that persist in patients that have been tested and received treatment for Helicobacter pylori and/ or been treated with a trial of PPI's for 6 weeks • Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease (i.e. anorexia and weight loss) or in patients > 45 years old • Dysphagia or Odynophagia • Oesophageal reflux symptoms that are persistent or recurrent despite appropriate treatment • Persistent vomiting of unknown cause • Biopsy for suspected coeliac disease • Other diseases in which the presence of upper GI pathologic conditions might modify other planned management • Familial adenomatous polyposis syndromes • For confirmation oand specific histologic diagnosis of radiological demostrated lesions - suspected neoplastic lesion, gastric ulcer oseophageal ulcer, upper tract stricture or osbtruction • Patients with active/recent GI bleeding • Iron deficiency anaemia or chronic blood loss • Patients with suspected portal hypertension to document or treat oesophageal varices • To assess acute injury after caustic ingestion • Treatment of bleeding lesions such as ulcers, tumours, vascular abnormalities (e.g. electro-coagulation, heater probe, laser photocoagulation, or injection therapy) • Banding or sclerotherapy of oesophageal varices • Removal of foreign body • Dilatation of stenotic lesions • Further investigation of suspected achalasia • Palliative treatment of stenosing neoplasms **Repeat Upper G.I. Endoscopy** No Consultant or hospital benefits are payable for a repeat upper G.I. endoscopy within a 12 month period except for the following clinical indications: **Ind. Code** • Histological diagnosis of gastric or oesophageal ulcer. • Coeliac Disease – re-check for healing 3 months (once only) • Achalasia • Post banding of oesophageal varices • Patients diagnosed with an atypical (non-H. pylori-associated) or high-risk duodenal ulcer - Benefit will be provided for one repeat endoscopy to re-biopsy (except by report) • Stent blockage • Re-biopsy of an oesophageal ulcer • Barretts Mucosa with dysplasia • Gastric mucosa showing dysplasia • Follow up of patients post gastric or oesophageal cancer. - Benefit will be provided for endoscopies as clinically indicated. New clinical indications, unrelated to the indications for an earlier endoscopy, within the 12 month period, themselves an identified indication(s) for endoscopy, will not be excluded by a prior endoscopy. Please refer to the initial endoscopy codes.

1.07	Clinical Indications for procedure code 198 are as follows: must be included on claim form for payment • Oesophageal Cancer: Pre-operative staging and assessment of the resectability in operable patients without distant metastases, especially when stage dependent treatment protocols are applied • 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) • Gastric Gastrointestinal sub mucosal tumours to differentiate from extra luminal compression and to plan therapy (resection or followup) • Gastric: For diagnosis of gastric malt lymphoma • Biliary tumours : Pre-operative staging and distal bile duct tumours • Benign conditions of the biliary tract; Microlithiasis associated with acute pancreatitis • Benign conditions of the biliary tract; Microlithiasis associated with acute pancreatitis / Post-cholecystectomy patients presenting with suspected biliary colic and have normal abdominal ultrasound and normal Liver Function Tests • Pancreatic Tumours: Staging • Neuroendocrine Tumours : locating neuroendocrine tumours, including insulinomas and gastrinomas
1.08	Vestibule is the part of the oral cavity outside the dentoalveolar structure; it includes the mucosal and submucosal tissues of lips and cheeks
1.10	Clinical Indications for procedure code 271 are as follows: Patients with a diagnosis of gastro-oesophageal reflex disease confirmed by both • Gastroscopy with photographic evidence of oesophagitis and • 24 hour monitoring positive for reflux, i.e. identifying – a pH of less than 4 or greater than 5% of the day and – a de Meester score greater than 15 and • Failure to respond to at least 8 weeks of treatment with proton pump inhibitors Code 271 is not claimable in conjunction with procedure codes 194, 590 or 5917
1.11	Clinical Indications for procedure codes 448 are as follows: • 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; • For initial diagnosis in persons with suspected Crohn's disease (abdominal pain, diarrhoea, elevated ESR, elevated white cell count, fever, gastrointestinal bleeding, or weight loss) without evidence of disease on conventional diagnostic tests, including small bowel follow through and upper and lower endoscopy; or • For treating members with gastrointestinal bleeding when the small intestine has been identified as the source of bleeding.
1.12	Clinical Indications for colonoscopy, proctoscopy or sigmoidoscopy procedure codes 450, 454, 455, 456, 457, 530, 535, 536 and 540 are as follows: Note: if CT Colonography or a barium enema is performed within 6 weeks of a colonoscopy, benefit for an incomplete colonoscopy only is payable (if performed) Initial Colonoscopy, Proctoscopy or Sigmoidoscopy
1.15	Paid once only for 1st session. For subsequent sessions use code 826
1.16	Paid once only for 1st session. For subsequent sessions use code 831
1.28	Where these procedures are done in an Outpatient setting there is an enhanced surgeon fee. See Minor Procedure list.

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Spinal Surgery

Spinal Surgery

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3555	Fractured spine, open reduction of, including spinal canal clearance of bony and disc material in a spinal trauma setting		
3571	Posterior spinal fusion with instrumentation for scoliosis (up to 8 levels)		26.01
35711	Posterior spinal fusion with instrumentation for scoliosis (over 8 levels)		26.01
3585	Spina bifida, lumbar spinal osteotomy (may include spinal chevron osteotomy up to 5 levels)		26.02
35851	Spina bifida, lumbar spinal osteotomy (may include spinal chevron osteotomy more than 5 levels)		26.02
35852	Pedicle subtraction osteotomy (all levels)		26.02
35853	Vertical Column resection		26.02
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)		
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		26.03
35871	Spinal fusion, simultaneous combined anterior and posterior fusion, multiple level, with instrumentation (insertion of rods, plates and/or screws and/or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer) up to 4 to 8 levels (I.P.)		26.03
35872	Spinal fusion, simultaneous combined anterior and posterior fusion, multiple level, with instrumentation (insertion of rods, plates and/or screws and/or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer) over 8 levels (I.P>0		26.03
3591	Closed reduction of cervical spinal fracture (s) / dislocation (I.P.)	I.P.	
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		26.04
35981	Spinal fusion, multiple level, with internal fixation (insertion of rods, plates and/or screws and/ or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer) – 4 to 8 levels (I.P.)		26.17
35982	Spinal fusion, multiple level, with internal fixation (insertion of rods, plates and/or screws and/ or the insertion of an artificial disc, and not simply the insertion of a stand-alone spacer) – over 8 levels (I.P.)		26.17
3599	Cervical spine laminoplasty with segmental plate fixation (I.P.)	I.P.	
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) 3606 Percutaneous vertebroplasty, single thoracic vertebra (may include Balloon kyphoplasty)		
3607	Percutaneous vertebroplasty, single lumbar vertebra (may include Balloon kyphoplasty		
3612	Posterior foramen magnum (I.P.)	I.P.	
5044	Replacement of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s) (IP)	I.P., Daycare	
5051	Replacement of spinal neurostimulator pulse generator or receiver direct or inductive coupling (I.P.)	I.P., Daycare	
5575	Injection of trigeminal ganglion or nerve under image guidance(IP)	I.P., Daycare	
5580	Destruction by radiofrequency lesioning of trigeminal ganglion under x-ray guidance via foramen ovale (IP)	I.P., Daycare	
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	
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	
5614	Peripheral nerve lesioning including pulsed radiofrequency or electrical stimulation (I.P.)	I.P., Daycare	
5615	Peripheral nerve block for pain control using nerve stimulation or ultrasound (I.P.)	I.P., Side Room	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5616	Neurodestructive thermal rhizotomy (temperature > 69°C), under image guidance, with sensory and motor testing, one or more levels, lumbar, sacral or thoracic (IP)	Daycare	26.06
5617	Neurodestructive thermal rhizotomy (temperature >69°C), under image guidance, with sensory and motor testing, one or more levels, cervical(IP)	I.P., Daycare	26.06
5618	Repeat of procedure 5616 to the same anatomical site, one or more levels, lumbar, sacral or thoracic (I.P.)	I.P., Daycare	26.06
5619	Repeat of procedure 5617 to the same anatomical site, one or more levels, cervical (I.P.)	I.P., Daycare	26.06
5620	Sympathetic block, under image guidance(IP)	I.P., Daycare	
5621	Intravenous block (Bier's technique)(IP)	I.P., Daycare	
5624	Injection, anaesthetic agent, intercostal nerve, single (I.P.)	I.P., Daycare	
5625	Injection, anaesthetic agent, intercostal nerve, multiple, regional block (I.P.)	I.P., Daycare	
5719	Chemical sympathectomy, lumbar or coeliac plexus under image guidance (I.P)	I.P.	
5721	Microneurosurgical subarticular fenestration and foramanal decompression including microdisectomy surgery using a microscope; with dynamic stabilisation interspinous implant; more than one level (unilateral or bilateral)		
5722	Microneurosergical subarticular fenestration and foraminal decompression including microdisectemy surgery using a microscope with dynamic stabilisation interspinous implant; re-exploration following previous surgery at the same interspace site(s), one or more levels (unilateral or bilateral)		
5724	Microneurosurgical subarticular fenestration and foraminal decompression including microdiscectomy surgery using a microscope with dynamic stabilisation interspinous implant; one level (unilateral or bilateral)		
5728	Microneurosurgical subarticular fenestration and foraminal decompression including microdisectomy surgery using a microscope; more than one level (unilateral or bilateral). This procedure is defined as requiring magnification and an extra light source from beginning to end of the procedure (i.e. excludes use of a microscope solely at the end of procedure)		
57281	Microneurosurgical far lateral disc removal (one or more levels) (I.P.)	I.P.	
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),. This procedure is defined as requiring magnification and an extra light source from beginning to end of the procedure (i.e. excludes use of a microscope solely at the end of procedure)		26.09
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		
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.		26.10
5732	Microneurosurgical subarticular fenestration and foraminal decompression including microdiscectomy surgery: on one or more levels, unilateral or bilateral. This procedure is defined as requiring magnification and an extra light source from beginning to end of the procedure (i.e. excludes use of a microscope solely at the end of procedure)		
5760	Lumbar puncture (I.P.)	I.P., Diagnostic	
5794	Percutaneous implantation of neurostimulator electrodes for faecal incontinence; permanent implantation		
5798	Costovertebral approach with decompression of spinal cord or nerve root(s); thoracic		
5799	Arthrodesis, anterior interbody fusion (ALIF)		
5929	Arthrodesis, posterior interbody fusion (PLIF)) including the insertion of interbody cage		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5934	Removal of spinal bone tumours		
5937	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical		
5964	Each additional interspace, cervical		
5969	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic		
5971	Vertebral corpectomy and grafting		
5972	Laminectomy with drainage of intramedullary cyst/syrinx		
5973	Laminectomy with release of tethered spinal cord		
5974	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord		
5976	Laminectomy for removal/biopsy extramedullary tumour		
5977	Laminectomy for removal/biopsy intramedullary tumour		
5978	Repair meningocoele/ myelomeningocoele		
5979	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural		
5984	Insertion of a spinal cord stimulator - trial stage	Pre Auth	26.12
5999	Insertion of a spinal cord stimulator - Implantation stage	Pre Auth	26.12
3520	Anterior drainage of paravertebral abscess with bone graft		
3521	Anterior release and fusion for scoliosis/kyphosis		
3525	Antero lateral decompression		
3526	Antero lateral decompression involving two or more levels		
3530	Coccyx, excision of		
3545	Epidural infusion with cannula	Day Care, Service	
3550	Fracture or fracture dislocation of spine traction, reduction and plaster cast application		
3560	Intervertebral disc, removal of		
3561	Needle aspiration of intervertebral disc	Side Room	
3563	Excision of thoracic intervertebral disc		
3565	Laminectomy and exploration with or without rhizotomy		
3566	Neuralarch biopsy		
3580	Spina bifida, closure of		
3588	Spinal fusion, simultaneous combined anterior and posterior fusion, one level, without instrumentation		
3589	Spinal fusion, simultaneous combined anterior and posterior fusion, multiple level, without instrumentation		
3590	Spinal manipulation, under general anaesthetic	Day Care	
3592	External fixature of the spine		
3595	Spinal fusion		
3596	Spinal fusion, in scoliosis spine, anterior and posterior		
3597	Spinal fusion involving two or more levels		
3609	Percutaneous vertebral augmentation, including cavity creation, using mechanical device, e.g. kyphoplasty, one level (unilateral or bilateral), lumbar		
3611	Percutaneous vertebral augmentation, including cavity creation, using mechanical device, e.g. kyphoplasty, one level (unilateral or bilateral), thoracic		
3600	Vertebral body biopsy	Diagnostic	
3602	Removal of spinal instrumentation		
3603	Spinal stenosis decompression, one level		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3604	Spinal stenosis decompression, two levels		
3608	Dynamic lumbar stabilisation with interspinous implant (Independent procedure)	I.P.	

SPINAL SURGERY - PAYMENT RULES

26.01	Note Code 3571 and 35711 cannot be charged together in any one specific case
26.01	Note Code 3571 and 35711 cannot be charged together in any one specific case
26.02	Note Code 3585, 35851 and 35852 cannot be charged together in any one specific case
26.03	Note Code 3587, 35871 and 35872 cannot be charged together in any one specific case
26.04	Note Code 3598, 35981 and 35982 cannot be charged together in any one specific case
26.05	Payable in full with main benefit
26.06	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 i.e.. 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.
26.07	Code 5711 is not claimable with Code 5712
26.08	Benefit is payable in full when performed with code 5711 or 5712
26.09	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
26.10	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
26.12	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 Irish Life Health and who also has a Diploma in Pain Medicine. (ii) The procedure is performed in a hospital that : - Is listed in the Irish Life Health 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 Irish Life Health in advance of treatment
26.17	Note Code 3598, 35981 and 35982 cannot be charged together in any one specific case

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Plastic Surgery

Breast Reconstruction

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
4477	Breast reconstruction with free flap, post-mastectomy DIEP (deep inferior epigastric perforators) - single surgeon - harvest and reconstruction	I.P., Pre-Auth	
44771	Flap implantation for breast reconstruction with free flap, post-mastectomy Diep (deep inferior epigastric perforators)- Dual Surgeons	I.P., Pre-Auth	6.04
44772	Flap harvest for breast reconstruction with free flap, post-mastectomy Diep (deep inferior epigastric perforators) - Dual Surgeon	I.P., Pre-Auth	6.05
4478	Breast reconstruction with pedicled transverse rectus abdominis myocutaneous flap (TRAM)	I.P.	
4479	Nipple reconstruction post mastectomy	Daycare	
4480	Breast reduction (Unilateral)	Pre-Auth 6.01	
44480	Breast reduction (Bilateral)	Pre-Auth	6.01
4482	Plastic repair of inverted nipple	Daycare	
4484	Mastopexy including full thickness graft from other areas post mastectomy (I.P.)	I.P.	6.02
4485	Breast reconstruction, vertical rectus flap, post mastectomy	I.P.	6.02
4486	Breast reconstruction, latissimus dorsi flap, with or without implant, post mastectomy	I.P.	6.02
4487	Breast reconstruction, other flap, with or without implant, post mastectomy	I.P.	6.02
4488	Mammoplasty, augmentation with prosthetic implant to restore symmetry	Pre-Auth	6.17
4504	Nipple - areola tattooing performed by a consultant (one or more visits)	Service, Side Room	6.03
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)		
44773	Free Fat injection, post mastectomy	I.P., Pre-Auth	6.06

Burns Wounds - Debridement - Grafting

4337	Debridement of wound, which may include skin, or subcutaneous tissue or muscle less than 9% of body surface		
4338	Debridement of wound, which may include skin, or subcutaneous tissue or muscle between 9% and 18% of body surface		
4339	Debridement of wound includes skin, and/or subcutaneous tissue, and/or muscle greater than 18% of body surface		
4371	Escharotomy		
4372	Acellular dermal replacement; first 100 sq.cm. or less, or 1% of body area of infants and children		6.07
4373	Acellular dermal replacement; each additional 100 sq. cm. or each additional 1% of body area of infants and children		6.07
4341	Debridement and skin grafting of wound less than 9% of body surface; includes excision of open wound, burn eschar or scar excision		
4342	Debridement and skin grafting of wound between 9% and 18% of body surface; includes excision of open wound, burn eschar or scar excision		
4343	Debridement and skin grafting of wound greater than 18% of body surface; includes excision of open wound, burn eschar or scar excision		
4405	Scar excisions (per scar) flexion, fingers, elbows, groin, knees	Daycare	
4410	Z plasty (per scar) flexion, fingers, elbows, groin, knees	Daycare	
4539	Secondary closure of wound or dehiscence, as a result of burn, includes excision of granulation and scar tissue; suturing in several layers, extensive site	I.P., Service	
4541	Skin grafting of granulating wound less than 9% of body surface		
4542	Skin grafting of wound between 9% and 18% of body surface		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
4543	Skin grafting of wound greater than 18% of body surface		
4385	Inlay grafts (ankle)		
4395	Inlay grafts (fingers)		
4400	Inlay grafts (knee)		

Cleft Lip and Palate

4415	Adjustment of lip margin		
4420	Adjustment of scars, secondary		
4425	Cleft palate reconstruction		
4430	Complete cleft lip and anterior palate repair		
4431	Primary repair, unilateral cleft lip		
4432	Primary repair, bilateral cleft lip		
4433	Secondary repair, unilateral cleft lip		
4434	Secondary repair, bilateral cleft lip	Daycare	
4440	Fistula, secondary closure of		
4460	Maxillary bone graft		
4465	Nostril margin, secondary correction of		
4466	Total cleft rhinoplasty		
4470	Pharyngoplasty (not for snoring)		
4475	Soft palate partial cleft, reconstruction of		

Cutaneous Flaps

4963	Excision of lesion including scalp rotation flap (IP)	I.P., Daycare	
4964	Excision of lesion including cheek rotation flap (IP)	I.P., Daycare	
4966	Excision of lesion including cervicofacial rotation flap (IP)	I.P., Daycare	
4967	Excision of lesion including forehead flap (IP)	I.P., Daycare	
4968	Excision of lesion including deltopectoral flap (IP)	I.P.	
4969	Excision of lesion including groin flap (IP)	I.P.	

Delayed Facial Re-animation

4494	Wedge excision of lower lip to restore oral continence in the presence of facial palsy	Side Room	
4496	Nasolabial skin/dermal hitch		
4497	Temporalis fascial sling, oral, nasolabial, ocular		
4498	Orbicularis oris hitch		
4499	Masseter to oral angle, digastric to lower lip or temporalis to fascial slings		
4500	Facial nerve graft (in face), (see E.N.T. operations for facial nerve graft in facial canal)		
4501	Cross facial nerve grafting, hypoglossal/facial nerve reanimation		
4502	Free muscle transfer, pectoralis minor, gracilis or extensor digitorum brevis as a second stage procedure to 4501		
4510	Facial reanimation in facial paralysis, unilateral		

Ear

4555	Accessory auricles, removal	Daycare	
4560	Epithelioma of ear, excision and reconstruction, lobule placement	Side Room	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
4561	Cartilage graft(s), reconstruction of ear		
4575	Protruding ears, correction with reconstruction of folds, bilateral	Daycare	6.08
4580	Protruding ears, correction of with reconstruction of folds, unilateral	Daycare	6.08

Eyes

4585	Reconstruction of contracted ocular socket		
4595	Enophthalmos, bone graft		
4605	Decompression, orbit		
4610	Eyebrow graft		
4615	Eyelids, repair of, for avulsion		
4620	Eyelid, inlay grafts (one lid)	Side Room	
4630	Eyelid, total reconstruction of	Daycare	
4635	Muscle advancement for ptosis, unilateral	Daycare	
4640	Naso lacrimal duct, reconstruction of		
4625	Eyelid operations in facial paralysis		6.18

Facial Trauma

4489	Facial trauma, suturing of facial nerve		
4491	Facial trauma, suturing of facial nerve branch		
4492	Facial trauma, grafting of facial nerve, sural nerve, greater auricular nerve		

Fascioutaneous Flaps

4971	Fasciocutaneous flap, upper limb(IP)	I.P.	
4972	Fasciocutaneous flap, lower limb(IP)	I.P.	
4973	Fasciocutaneous flap, trunk(IP)		

Facial Tumours

4493	Excision of facial nerve and graft, sural nerve, greater auricular nerve		

Free Microvascular Flaps

4513	Free skin and/or muscle flap with microvascular anastomosis		
4514	Free osteocutaneous flap with microvascular anastomosis, any area		
4951	Free flap (microvascular transfer) to face, complete procedure		

Genito Urinary

4686	Cliteroplasty		
4690	Vaginal reconstruction with skin graft		

Hands

4695	Congenital hand deformities, reconstruction on each hand (per stage)		
4700	Congenital hand deformities, moderate repairs on each hand (per stage)	Daycare	
4705	Contractures, extensive, straightening of hand and inlay grafts		
4710	Contractures, localised, division and graft		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
4711	Dermofasciectomy, removal of flexor skin, full thickness skin graft including distal or full palm, one finger		
4712	Dermofasciectomy, removal of flexor skin, full thickness skin graft including distal or full palm, one finger including simple fasciectomy to another finger		
4715	Dupuytren's contracture, fasciectomy (one or two fingers)	Daycare	
4720	Dupuytren's contracture, fasciectomy (three or more fingers)	Daycare	
4721	Dupuytren's contracture, palm and fingers	Daycare	
4730	Injury to hand, major, multiple repair of tendons, nerves and skin		
4735	Injury to hand, moderate, wound repair or graft		
4740	Island grafting, for sensory loss, finger and/or thumb		
4745	Neoplasm, major excision and repair with tendon grafts and flaps		
4750	Neoplasm, localised excision and graft	Daycare	
4760	Nerve repair, primary, single or multiple	Daycare	
4765	Nerve repair in extensively scarred hand		
4770	Opposition strut graft to thumb		
4775	Palmar ganglion, compound, synovectomy of	Daycare	
4780	Policisation (finger replacement of lost thumb)		
4781	Repair of bifid thumb		
4782	Toe to hand transfer		
4783	Sympathectomy, digital arteries, each digit with magnification		
4785	Syndactyly, repair of, single		
4790	Syndactyly, repair of, multiple		
4795	Tendon grafting, single		
4800	Tendon grafting, multiple	Daycare	
4805	Tendon repair, single		
4810	Tendon repair, multiple		
4815	Tendon transplants, for restoration of opposition		
4820	Tendon transfers for paralysis, multiple		
4825	Tube pedicle or flap reconstructions, first stage		
4830	Tube pedicle or flap reconstructions, second stage		
4835	Tube pedicle or flap reconstructions, final stage		
4722	Dupuytren's contracture, using Collagenase Clostridium Histolyticum (Xiapex), palms and fingers	I.P., Daycare, Service	

Foot

4836	Release of syndactyly; toes (I.P.)	I.P.	

Local Grafts and Flaps

4949	Excision of pressure sore and local cutaneous flap (IP) I.P.		
4952	Excision or debridement of pressure sore and split skin graft I.P.		
4937	Excision of benign or malignant lesion(s), any area; adjacent tissue transfers or rearrangement, 4 sq. cm or less	Side Room/ Outpatient	6.09, 6.28
4938	Excision of benign or malignant lesion(s), any area; adjacent tissue transfer or rearrangement, 4.1 sq. cm to 10 sq. cm	Side Room	6.09

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
4939	Excision of benign or malignant lesion(s), any area; adjacent tissue transfers or rearrangement, 10.1 sq. cm to 30 sq. cm	Daycare	6.09
4941	Excision of benign or malignant lesion(s), any area; adjacent tissue transfer or rearrangement, 30.1 sq. cm or larger	Daycare	6.09
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)		6.09, 6.15
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)		6.09, 6.15
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)		6.09, 6.15

Maxilla and Mandible

4845	Facial bone, simple fixation of undisplaced fracture (e.g. jaw sling)		
4850	Facial bones, tumours of, major resection and/or reconstruction		
4855	Fracture of maxilla or mandible, open reduction and fixation		
4860	Fracture of maxilla or mandible, fixation of undisplaced		
4865	Fracture of maxilla or mandible, malar bone or part of these, reduction without fixation		
4870	Hypertelorism correction, sub cranial		
4875	Mandible, excision of		
4880	Maxilla or mandible, advancement or recession osteotomy of		
4881	Maxillary and mandibular osteotomy		
4882	Lengthening of the mandible by gradual distraction for congenital hemifacial microsomia	Pre-Auth	
4883	Surgically assisted rapid maxillary expansion	Pre-Auth	
4885	Orbital floor, fracture of, reduction, direct wiring and build up from antrum		
4890	Orbital floor, secondary bone grafting		
4895	Osteomyelitis or abscess of facial bones, operation for	Daycare	
4900	Temporo mandibular joint, reduction of dislocation under general anaesthetic	Daycare	
4901	Arthroscopy, temporo mandibular joint for release of adhesions or arthroplasty, with or without biopsy	Daycare, Service	6.10
4905	Temporo mandibular joint, condylectomy for ankylosis		

Myocutaneous Flaps

4944	Excision of pressure sore and myocutaneous flap		6.11
4974	Myocutaneous flap, pectoralis		6.11
4976	Myocutaneous flap, latissimus dorsi		6.11
4977	Myocutaneous flap, latissimus dorsi with serratus and rib		6.11
4978	Myocutaneous flap, vertical rectus		6.11
4979	Myocutaneous flap, transverse rectus (TRAM)		6.11
4981	Myocutaneous flap, tensor fascia lata		6.11

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
4982	Myocutaneous flap, gluteal		6.11

Nose

4910	Bone graft		
4915	Nasal tip deformities, correction of		
4920	Fracture of nose, digital closed reduction	Daycare	
4925	Fracture of nose, instrumental closed reduction	Daycare	
4926	Fracture of nose, instrumental closed reduction with plaster of Paris fixation	Daycare	
4927	Fracture of nose, instrumental closed reduction with reduction of septum and plaster of Paris fixation	Daycare	
4930	Fracture of nose, open reduction	Daycare	
4935	Fracture of nose, open reduction with internal or external fixation	Daycare	
4940	Fracture of nose, open reduction with open reduction of fractured septum	Daycare	
4945	Reconstruction with imported flaps, partial	Daycare	
4950	Reconstruction with imported flaps, total		
4955	Re fracture and open corrective rhinoplasty including nasal tip deformities (code 4915), unless demonstrable evidence discloses significant nasal tip deformity being corrected	I.P., Daycare	
30120	Rhinophyma (I.P.)	Pre-Auth, I.P.	6.12

Other Procedures

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 Irish Life Health only (I.P.)	I.P., Side Room Service	
4547	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen; infraumbilical panniculectomy	Pre-Auth	6.13
5630	Repair of cirsoid aneurysm of the scalp		
4538	Treatment of superficial wound dehiscence; simple closure with or without packing (single layer closure) Service		
4983	Botox for hyperhydrosis (I.P.) I.P. 6.14		
45461	Keloids and hypertrophic scars intralesional injection of triamcinolone; up to and including the sixth lesions, Under 12 in an Irish Life Health approved hospital(I.P.)	I.P., Side Room, Service	
3061	Giant Cell Tumour, excision of primary or recurrent lesion from bone or soft tissue	I.P.	

Replantation

4991	Replantation, per digit		
4992	Replantation, hand (mid palm)		
4993	Replantation, hand (wrist)		
4994	Replantation, forearm		
4996	Replantation, foot		
4997	Replantation, scalp following major trauma only		
4998	Replantation, ear		
4999	Replantation of thumb including carpometacarpal joint to metacarpophalangeal joint, complete amputation, with or without microvascular anastomosis		

Tissue Expanders

4551	Insertion of tissue expanders (other than breast) includes subsequent expansion(s)		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
4552	Removal of expander (other than breast)		
4553	Removal of expander (other than breast) and inserting of expanded skin		
4554	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction		
4556	Delayed (or immediate by a second surgeon at the time of the primary surgery) insertion of breast prosthesis or expander (includes subsequent expansions) following mastopexy, mastectomy or in reconstruction	I.P.	
4557	Replacement of tissue expander with permanent prosthesis	I.P.	

Trauma

4990	Major degloving injuries of limbs, excision and graft of		

PLASTIC SURGERY - PAYMENT RULES

6.01	Benefit for payment for Breast reduction will be provided in the following circumstances: • BMI < 25 • Bra cup size >/=F • 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
6.02	Post Mastectomy Only
6.03	Benefit payable following breast reconstruction procedures which were eligible for Irish Life Health benefit and when carried out by Consultant Plastic Surgeon registered with Irish Life Health
6.04	Paid at 100% in conjunction with code 44772
6.05	Paid at 100% in conjunction with code 44771
6.06	For correction of breast defect post breast reconstruction surgery (non cosmetic). Limit of 1 per lifetime
6.07	For codes 4372 and 4373 a comprehensive report must be provided on the claim form detailing body area and square cm involved.
6.08	Benefit only payable for patients up to eighteen years of age
6.09	Note: Procedure codes 4937, 4938, 4939, 4941, 4942, 4943 and 4946 are only payable to Consultants Plastic Surgeons and the following notes apply: • payable for: Z-plasty, W-plasty, V-Y plasty, local flap, transposition flap, distant flap rotation flap, random island flap, advancement flap. • Undermining of adjacent tissue to achieve closure, without additional incisions, does not constitute adjacent tissue transfer. • Skin grafting where necessary to close secondary defect is considered an additional procedure, refer to codes 4942, 4943 and 4946. This is applicable to consultants with relevant specialist training in this area and registered as such with Irish Life Health.
6.11	Payable in full with primary procedure
6.12	Supported by a Consultant report and photographic evidence
6.13	Benefit is payable for procedure code 4547 only in the following circumstances: • For members who have had bariatric surgery for which Irish Life Health have paid benefit; and • Where the panniculus hangs below the level of the pubis; and the medical records document that the panniculus causes chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing) that consistently recurs over 3 months while receiving appropriate medical therapy, or remains refractory to appropriate medical therapy over a period of 3 months. Pre certification required.
6.14	As a result of a positive Bromide Iodine Starch Test or following a referral from a Consultant having failed a proscribed course of topical treatment (maximum 2 per annum)
6.15	The Doner site for grafting material must be specified on the claim form
6.16	Payable in full with primary procedure
6.17	Benefit for corrective surgery for breast asymmetry will be provided in the following circumstances: • 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 • Restoration of symmetry following mastectomy
6.18	Visual fields must be supplied with claim form
6.28	Where these procedures are done in an Outpatient setting there is an enhanced surgeon fee. See Minor Procedure list.

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Thoracic Surgery

Lungs

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5015	Lung abscess with thoracotomy, drainage of		
5025	Pneumonolysis		

Bronchi / Lungs / Pleura

5941	Total pneumonectomy		
5942	Lobectomy of lung (including excision of segment)		
5943	Thoracoscopic lung resections	I.P.	
5944	Open excision of lesion of lung		
5946	Decortication of pleura or lung, open or thorascopic	I.P.	
5947	Removal of lung, with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)		
5948	Removal of lung, with circumferential resection of segment of bronchus followed by bronchobronchial anastomosis (sleeve lobectomy)		
5949	Pleurectomy for pneumothorax, open		
5951	Endoscopic examination of pleura	I.P.	
5952	Insertion of tube drain into pleural cavity		
5953	Introduction of substance into pleural cavity with chest aspiration		
5954	Introduction of substance into pleural cavity with chest drain		
5982	Total pneumonectomy with lymphadenectomy		
5983	Lobectomy of lung (including excision of segment) with lymphadenectomy		

Chest Wall

5907	Repair of congenital diaphragmatic hernia using thoracic approach in neonates		8.01
5908	Thoracoplasty, one stage		
5909	Excision of chest wall tumour including ribs		
5912	Correction of pectus deformity of chest wall		
5913	Reconstruction of chest wall		
5914	Exploratory thoracotomy		
5916	Resection of rib and open drainage of pleural cavity		
5917	Repair of rupture of diaphragm		8.02
5918	Plication of paralysed diaphragm		
5927	Cervical rib resection for thoracic outlet syndrome		
5963	Repair of diaphragmatic hernia using thoracic approach		

Fibreoptic Endoscopic Procedures

5931	Destruction of lesion of trachea		
5932	Dilatation of tracheal stricture		
5936	Dilatation of bronchial stricture by fibreoptic bronchoscopy		

Great Vessels

5125	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis (artificial valve) and coronary reconstruction		
5126	Transverse arch graft, with cardiopulmonary bypass		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5127	Descending thoracic aorta graft, open or endovascular, with or without bypass, with or without coverage of left subclavian artery origin, plus descending thoracic aortic origin extension(s), if required to level of coeliac origin		
5128	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass		
5143	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; without cardiopulmonary bypass		
5144	Repair of hypoplastic or interrupted aortic arch using autogenous or prosthetic material; with cardiopulmonary bypass		
5146	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension		
5147	Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with coronary reconstruction		
5871	Open correction of patent ductus arteriosus		
5879	Correction of truncus arteriosus		
5882	Closed correction of patent ductus arteriosus		
5883	Creation of shunt to pulmonary artery from aorta using interposition tube prosthesis		
5884	Pulmonary artery banding		
5886	Connection to pulmonary artery from aorta		
5887	Creation of shunt to pulmonary artery from subclavian artery using interposition tube prosthesis		
5888	Connection to pulmonary artery from subclavian artery		
5889	Repair of pulmonary artery/PA De Banding		
5892	Pulmonary embolectomy		
5893	Open operations on pulmonary artery		
5894	Extra anatomic bypass of aorta		

Heart

5131	Open procurement of a radial artery to secure conduit for construction of a coronary artery bypass graft (payable in full with main benefit)		8.03
5134	Operative ablation/incision and/or reconstruction of atria for treatment of atrial fibrillation or flutter (e.g. maze procedure)		
5138	Operative ablation of atrial fibrillation, supraventricular arrhythmogenic focus or pathway (e.g., Wolff-Parkinson-White, atrioventricular node re-entry), tract(s) and/or focus (foci) with or without cardiopulmonary bypass		
5139	Operative ablation of atrial fibrillation, ventricular arrhythmogenic focus with cardiopulmonary bypass		
5141	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular		
5142	Removal of single or dual chamber pacing cardioverterdefibrillator electrode(s); by thoracotomy		
5156	Coronary Artery bypass graft, vein only, one or more coronary venous grafts		
5157	Coronary Artery bypass grafts using venous graft(s) and a single arterial graft		
5158	Coronary Artery bypass grafts using venous graft(s) and arterial grafts		
5166	Revision Coronary Artery bypass graft, vein only, one or more coronary venous grafts		
5167	Revision Coronary Artery bypass grafts using venous graft(s) and a single arterial graft		
5168	Revision Coronary Artery bypass grafts using venous graft(s) and arterial grafts		
5223	Insertion of permanent pacemaker with epicardial electrode(s), by thoracotomy		
5808	Transplantation of heart		
5809	Correction of tetralogy of fallot		
5811	Atrial inversion for transposition of great vessels		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5812	Other correction of transposition of great vessels		
5813	Correction of total anomalous pulmonary venous connection		
5814	Closure of defect of atrioventricular septum using dual prosthetic patches		
5816	Closure of defect of interatrial septum		
5817	Closure of defect of interventricular septum		
5818	Planned repair of post infarction ventricular septal defect		
5819	Emergency repair of post infarction ventricular septal defect		
5821	Other open operations on the septum of the heart		
5822	Creation of valved cardiac conduit		
5823	Creation of other cardiac conduit		
5824	Refashioning of atrium (Ebstein's)		
5826	Operations on wall of atrium		
5827	Excision of cardiac tumour		
5828	Staged correction of hypoplastic left heart syndrome, per stage		
5829	Replacement of mitral valve (includes valvuloplasty)		
5831	Plastic repair of mitral valve		
5832	Replacement of aortic valve (includes valvuloplasty)		
5833	Replacement of tricuspid valve (includes valvuloplasty)		
5834	Replacement of pulmonary valve (includes valvuloplasty / valvotomy)		
5837	Closed valvotomy		
5839	Double valves		
5841	Removal of obstruction from structure adjacent to valve of heart		
5842	Triple valves		
5852	Correction of anomalous coronary arteries		
5854	Map guided surgery for ventricular arrhythmias		
5857	Left ventricular aneurysmectomy		
5859	Insertion, management and removal of ventricular assist device		
5861	Insertion, maintenance and removal of aortic counterpulsation balloon pump		
5867	Removal of pacing system with bypass		
5872	Excision of pericardium	I.P.	
5873	Decompression of cardiac tamponade (re operation for bleeding)		
5874	Pericardiocentesis		
5876	Transthoracic drainage of pericardium		
5877	Creation of pericardial window or partial resection for drainage (I.P.)	I.P.	
5878	Closure of median sternotomy separation with or without debridement (I.P.)	I.P.	
5959	Revision of Valve surgery		
5033	Thorascopic epicardial radiofrequency ablation; operative tissue ablation with or without reconstruction of atria (e.g. modified maze procedure) without cardiopulmonary bypass (I.P.)	I.P.	8.04

Mediastinum

5041	Myocardial biopsy	Diagnostic	
5055	Aortic endarterectomy		
5075	Blalock operation		
5092	Venotomy and insertion of filter into the inferior vena cava (includes venogram)		
5110	Thoracoscopy, surgical; with oesophagomyotomy (Heller type)		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5113	Pericardial drainage		
5114	Continuous pericardial drainage		
5118	Atherectomy		
5120	Excision of mediastinal tumour		
5121	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach		
5122	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy		
5123	Excision of mediastinal cyst		
5124	Mediastinoscopy, without biopsy (I.P.)	I.P., Diagnostic	
5135	Mediastinoscopy and biopsy	Diagnostic	
5136	Percutaneous transthoracic biopsy	Diagnostic	
5137	Percutaneous transthoracic biopsy under CAT guidance	Diagnostic	
5148	Laparoscopy, surgical, oesophagomyotomy (Heller type) with fundoplasty, when performed		
5151	Percutaneous trans septal mitral valvuloplasty	I.P.	
5152	Valvuloplasty (other than mitral valvuloplasty)		
5161	Tracheo-oesophageal fistula, repair of		
5162	Repair, tracheo-oesophageal atresia		
5163	Repair, tracheo-oesophageal fistula (TOF) alone (H-fistula)		
5164	Repair, tracheo-oesophageal fistula (TOF) and atresia, replacement		
5165	Oesophagectomy (all forms including three stages)	I.P.	
5171	Transection of oesophagus with repair, for oesophageal varices		
5172	Oesophageal devascularisation		
5180	Pott's operation		
5190	Rashkind septostomy		
5205	Vagotomy (through chest)		
5217	Needle biopsy, transthoracic	Diagnostic	
5218	Needle biopsy, abdominal	Diagnostic	
5219	Trans thoracic electro-cautery of subclavian lymph nodes		
5801	Exploration of mediastinum	Diagnostic	
5802	Endoscopic extirpation of lesion of mediastinum	Diagnostic	
5804	Operation on lymphatic duct		
5855	Annuloplasty		
5863	Thymectomy		
5870	Myocardial aneurysmyotomy		

Pleura

5221	Closed pleural biopsy	Diagnostic	
5230	Empyema, drainage of (I.P.)	I.P.	
5231	Percutaneous drainage of empyema		
5234	Paracentesis thoracis (I.P.)	I.P., Diagnostic	
5235	Paracentesis thoracis with intercostal drain (I.P.)	I.P., Diagnostic	
5245	Phrenic avulsion (I.P.)	I.P.	
5250	Pleurodesis	I.P.	
5251	Closed drainage of pneumothorax		
5260	Thoracoscopy (I.P.)	I.P., Diagnostic	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5265	Thoracoscopy with intrapleural procedure	I.P.	
5270	Thoracotomy including lung or pleural biopsy (I.P.)	I.P., Diagnostic	
5274	Exploration for post-operative haemorrhage or thrombosis, chest		

Revision Surgery

5957	Revision repair of coarctation of aorta		
5958	Revision closure of defect of intra ventricular septum		

Trachea

5919	Partial excision of trachea		
5920	Reconstruction of trachea		
5921	Tracheostomy, permanent		8.05
5922	Insertion of mini tracheostomy		8.05
5923	Destruction of lesion of trachea by rigid endoscopy		
5924	Dilatation of tracheal stricture by rigid endoscopy		
5928	Therapeutic operations on bronchus or lung using rigid bronchoscopy		

THORACIC SURGERY - PAYMENT RULES

8.01	The anaesthetist benefit is all inclusive of pre-operative and post-operative intensive care. No other anaesthetic or intensive care benefits are payable
8.02	Procedure code 5917 is not payable in conjunction with procedure code 271
8.03	Payable in full with main benefit
8.04	Conditions of payment for code 5033 are as follows: • 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 • Relevant documentation confirming the above must be provided when the claim is being submitted
8.05	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

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Ear, Nose and Throat

Ear

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1665	Atresia of auricle, 2 or 3 stages, correction of (per stage) (I.P.)	I.P.	
1666	Attico antrostomy, unilateral		
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	
1671	Debridement of ear canal and microinspection of tympanic membrane unilateral or bilateral, requiring the use of an operating microscope and a hospital operating theatre e.g. in chronic otitis media or keratosis obturans (not for routine syringing, cleaning or the removal of impacted cerumen) (I.P.)	I.P., Side Room, Service	
1672	Labyrinthotomy, with or without cryosurgery including other non excisional destructive procedures or perfusion of vestibuloactive drugs, single perfusion, transcanal	Side Room	
1675	Drainage external ear, abscess or haematoma	Daycare	
1680	External auditory canal, excision of tumour	Daycare	
1685	External auditory canal, removal of exostosis or osteoma		
1686	External auditory canal, reconstruction of (meatoplasty) (e.g. for stenosis due to trauma, infection) (I.P.)	I.P., Daycare	
1690	Facial nerve decompression (in temporal bone)		
1695	Facial nerve graft (in temporal bone)		
1700	Foreign body, removal from ear, under general anaesthetic (I.P.)	I.P., Daycare	
1701	Labyrinthectomy; transcanal		
1710	Mastoidectomy, radical with or without labyrinthectomy		
1715	Mastoidectomy, simple		
1730	Myringoplasty, surgery confined to drumhead and donor area (not for the removal of myringotomy tubes) (I.P.)	I.P., Daycare	
1735	Myringotomy, unilateral	Daycare	
1740	Myringotomy, bilateral	Daycare	
1741	Removal of drain tube(s) under general anaesthetic	Daycare	
1751	Pinna, total excision		
1752	Pinna, partial excision with flap reconstruction	Side Room	
1753	Pinna, partial excision and graft	Daycare	
1755	Preauricular sinus, excision of	Daycare	
1760	Saccus endolymphaticus for Meniere's Disease		
1770	Stapedectomy		
1771	Stapedectomy with plastic reconstruction of ossicles		
1785	Myringotomy with insertion of grommet	Daycare	
1786	Myringotomy, bilateral, with insertion of grommets	Daycare	
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	
1790	Tympanoplasty with elevation of tympanomeatal flap (I.P.)	I.P., 1 Night Only	
5980	Combined approach tympanoplasty (with mastoidotomy)	1 Night Only	

Nose

1800	Epistaxis - anterior packing and/or cautery (I.P.)	I.P., Side Room/ Outpatient, Service	10.28
1805	Epistaxis - posterior packing and/or cautery (I.P.)	I.P., Daycare	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1810	Epistaxis, anterior ethmoidal and/or internal maxillary artery ligation (I.P.)	I.P.	
1815	Foreign body, removal from nose, under general anaesthetic	Daycare	
1820	Polypectomy, single (I.P.)	I.P., Daycare	
1825	Polypectomy, multiple (I.P.)	I.P., Daycare	
1879	Nasal/sinus endoscopy, surgical, with control of nasal haemorrhage, when medically necessary to perform under general anaesthetic	I.P., Daycare	

Nose and Accessory Sinuses

1895	Repair of choanal atresia, transpalatine		
1745	Nostril closure, for atrophic rhinitis		
1830	Accessory sinuses, open operations on, unilateral (including Caldwell Luc)		
1840	Accessory sinuses, open operations on, bilateral (including Caldwell Luc)		
1850	Antral biopsy Diagnostic		
1855	Antral puncture (antrotomy) and washout unilateral (I.P.)	I.P., Side Room	
1860	Antral puncture (antrotomy) and washout bilateral (I.P.)	I.P., Daycare	
1875	Sinusotomy with or without biopsy, with mucosal stripping or removal of polyp(s)	Daycare	
1880	Nasal/Sinus endoscopy, surgical, with antrostomy, unilateral	1 Night Only	
1885	Nasal/Sinus endoscopy, surgical, with antrostomy, bilateral	1 Night Only	
1890	Repair of choanal atresia, intranasal		
1896	Crawford tube insertion, unilateral		
1897	Crawford tube insertion, bilateral		
1900	Ethmoid area, malignant tumour excision		
1904	Nasal/sinus endoscopy (using an endoscope), diagnostic, unilateral or bilateral (this code is not payable for planned routine follow-ups to any other ENT procedure e.g. for splint, removal, washout, healing check etc.)	I.P., Diagnostic, Side Room	
1905	Nasal/Sinus endoscopy, surgical; with biopsy, polypectomy or removal of diseased mucosa, lesions or debridement (this code is not payable for planned routine follow-ups to any other ENT procedure e.g. for splint, removal, washout, healing check etc.)	I.P., Diagnostic, Side Room	
1910	Ethmoidectomy, extranasal, unilateral		
1915	Ethmoidectomy, extranasal, bilateral		
1920	Ethmoidectomy, intranasal, unilateral	1 Night Only	
1925	Ethmoidectomy, intranasal, bilateral (includes Code 1992)	1 Night Only	
1935	External frontal sinus exploration		
1940	External frontal sinus operation for malignant disease		
1945	External rhinotomy (with drainage of ethmoid frontal, or maxillary sinuses)		
1968	Nasal septum, insertion of prosthetic button	Daycare	
1969	Plastic repair of nasal septum (complete procedure, includes the removal of splints, washouts. Procedure codes 1904 or 1905 are not payable at a subsequent session)	I.P., 1 Night Only	
1970	Nasal septum, submucous resection of		
1980	Naso pharyngeal tumour, excision of		
1985	Oro antral fistula, closure of by means of surgical advancement of mucoperiosteal flap (does not apply for simple suturing or closure of socket immediately following extraction e.g. tooth/teeth)	I.P., Daycare	
1990	Cauterisation and/or ablation, mucous of turbinates, unilateral or bilateral, any method, superficial (I.P.)	I.P., Daycare	
1992	Nasal/Sinus endoscopy, surgical with ethmoidectomy (partial or total) bilateral 1 Night Only		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
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		10.02
4525	Rhinoplasty (I.P.) (complete procedure, includes the removal of splints, washouts. Procedure codes 1904 or 1905 are not payable at a subsequent session)	I.P., 1 Night Only	
5975	Rhinoplasty, primary, including major septal repair (complete procedure, includes the removal of splints, washouts. Procedure codes 1904 or 1905 are not payable at a subsequent session)	I.P., 1 Night Only	

Other Procedures

2113	Full pulmonary function studies for the diagnosis and assessment of obstructive or restrictive lung disease.	I.P., Diagnostic, Side Room	10.03, 10.04, 10.05
2117	Polysomnography, limited sleep study together with initiation of nasal CPAP titration for sleep apnoea performed during the same admission (I.P.)	I.P., 1 Night Only	10.06, 10.07
2118	Polysomnography, limited sleep study together with two nasal CPAP titration procedures for sleep apnoea performed during the same admission (I.P.)	I.P.	10.06, 10.07
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.)	I.P.	10.08, 10.10,
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.)	I.P.	10.11
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.)	I.P.	10.08
2139	Polysomnography, full study	1 Night Only, Service	10.10, 10.07
2141	Prolonged post exposure evaluation of bronchospasm after exercise, with multiple spirometric determinations as in 2113 including measurement of thoracic gas volume and expired gas determinations	Service, Side Room	
2142	Polysomnography, limited sleep study	1 Night Only, Service	10.06, 10.07, 10.10
2143	Polysomnography, full study with initiation of nasal continuous airway pressure (CPAP) titration for sleep apnoea (I.P.)	1 Night Only, I.P., Service	10.08, 10.07, 10.10
2144	Nasal CPAP titration for sleep apnoea (I.P.)	I.P., Service, 1 Night Only	10.08
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		10.11
2157	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate and oxygen saturation, unattended by a technologist (I.P)	I.P., 1 Night Only	

Throat

2053	Aryepiglottoplasty for the management of laryngomalacia in a multi-disciplinary team approach to care for a child under one year of age		
1994	Bronchoscopy; diagnostic, flexible with or without one of the following: (a) bronchoalveolar lavage, (b) cell washing or brushing,(c) bronchial biopsy (I.P.)	I.P., Diagnostic, Side Room	
1995	Abscess (retropharyngeal), incision and drainage (internal pharyngotomy)		
1999	Bronchoscopy with laser ablation/ resection of tumour (I.P.)	I.P.	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2004	Bronchoscopy; with transbronchial biopsy of tumour(s), nodule(s) or lymph node(s) with or without fluoroscopic or endobronchial ultrasound (EBUS) guidance (includes washing or brushings, if performed)	I.P., Diagnostic, Daycare, MAC	
2007	Inhalation bronchial challenge with histamine, methacholine, or similar compounds(IP)	I.P., Side Room, Service	
2012	Bronchoscopy with or without bronchial biopsy (claimable for patients less than 2 years old)	I.P., Diagnostic	
2013	Bronchoscopy; rigid, under General Anaesthetic	I.P., Diagnostic, Daycare	
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	
2020	Bronchoscopy with removal of foreign body (includes foreign body removal by rigid endoscopy) (I.P.)	I.P., Diagnostic	
2030	Laryngoscopy, flexible/rigid under topical anaesthesia	I.P., Diagnostic, Side Room, Service	
2031	Laryngoscopy, direct, operative with biopsy (I.P.)	I.P., Daycare, Service	
2032	Laryngoscopy, direct, with or without tracheostomy, with dilatation (I.P.)	I.P., Daycare, Service	
2040	Laryngectomy, all forms including vertical hemi laryngectomy and tracheostomy		
2050	Laryngofissure, external operation on		
2051	Laryngoplasty, (type 1 thyroplasty) including transcervical placement of an implant (e.g. for burns, reconstruction after partial laryngectomy or post thyroid surgery		
2054	Microsurgery with CO2 laser for the complete removal of laryngeal cancer		
2055	Lateral pharyngotomy		
2056	Microsurgery of larynx with complete removal of benign or malignant lesions (not for biopsy of lesions - code 2031) (I.P.)	I.P., Daycare	
2057	Vocal cord augmentation (injection of teflon)		
2058	Botulinum toxin injections for laryngeal dysphonia	Side Room, Service	
2085	Pharyngeal pouch or diverticulum, excision of		
2090	Pharyngeal pouch or diverticulum, endoscopic diathermy division		
2096	Drainage and marsupialisation of cyst Daycare		
2100	Pharyngolaryngectomy		
2115	Incision and drainage, abscess; retropharyngeal or parapharyngeal		
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		
2125	Tonsils and/or adenoids (adults), removal of	1 Night Only	
2130	Tonsils and/or adenoids (children under 12 years), removal of	1 Night Only	
2131	Tonsils or tonsils and adenoids, secondary surgical intervention for the arrest of haemorrhage requiring general anaesthetic, following the first operation		
2132	Tracheoesophageal puncture and insertion of prosthesis		
5900	Cricopharyngeal myotomy (I.P.)	I.P.	

EAR, NOSE AND THROAT - PAYMENT RULES

10.02	A copy of CT scan must be made available when requested, to include for purposes of clarification Code 1922 and/or Code 1925
10.03	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 reversibility 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.
10.04	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.
10.05	Where performed in an approved Irish Life Health Laboratory - list available from Irish Life Health on request.
10.06	Code 2117, 2142, 2118 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 a Irish Life Health recognised sleep laboratory. Polysomnography must include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram.
10.07	Reimbursement for procedures 2139, 2142, 2117 or 2118 is not claimable in the following circumstances except by special report to and agreement of Irish Life Health'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 hypo ventilating and who are free of polycythaemia, 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.
10.08	Codes 2119, 2122, 2143, 2144 refer to 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 apnoea's previously diagnosed by polysomnography. The study should least 6 hours and be attended by a technologist with Physician review, interpretation and report.
10.10	• Codes 2139, 2143 and 2119 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. • Polysomnography must include sleep staging (defined below) with 4 or more additional parameters of sleep, attended by a Technologist in a Irish Life Health recognised laboratory. • 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 activitymovement; 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.
10.11	Payable in the following circumstances only: - (a) When excessive daytime sleepiness interferes with the performance of routine daily tasks and clinical features do not suggest a diagnosis of sleep apnoea. -(b) 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.
10.12	Includes Code 1992
10.28	Where these procedures are done in an Outpatient setting there is an enhanced surgeon fee. See Minor Procedure list.

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Cardiology Procedures

For all procedures listed in cardiology section if more than one is performed on a patient (whether one or more consultants are involved), during a hospital stay, benefit will be payable as follows: 100% of the highest valued procedure, 50% of the second highest valued procedure, and 25% of the third highest valued procedure.

Cardiology Procedures

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
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).	Side Room	
5022	Cardiovascular stress test with pharmaceutical/chemical agent(s) includes IV administration, echocardiography ECG with consultant cardiologist in constant attendance.		
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	Daycare	

Angiogram

5058	Cardiac catheterisation and coronary angiography with or without ventriculography with fractional flow reserve (FFR) intracoronary pressure measurements	Diagnostic, Daycare	9.01
5080	Cardiac catheterisation (left, right or both sides) (I.P.)	I.P., Diagnostic, Daycare	
5090	Cardiac catheterisation and coronary angiography with or without ventriculography.	Diagnostic, Daycare	9.01
5200	Transeptal left heart catheterisation.		

Echo

5008	Cardiac ultrasound, (echocardiography) for patients on cytotoxic chemotherapy	Diagnostic, Side Room, Service	9.03
5109	Echocardiography, transoesophageal, real-time with image documentation (2D) (with or without M-mode recording), including probe placement, image acquisition, interpretation and report	Diagnostic, Side Room, Service	9.03
5108	Cardiac ultrasound, (echocardiography)	Outpatient, Diagnostic, Service	9.03

Electrophysiologic Studies

5079	Biventricular pacing - insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system).		9.05
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.		
5960	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement.		
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.		

Pacemakers

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
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)		9.08
5054	Removal of implantable, patient-activated cardiac event loop recorder (where the original implantation met the conditions of payment)		
5063	Removal of single or dual chamber pacing cardioverter/defibrillator electrode(s); by transvenous extraction.		
5065	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter		
5069	Insertion of automatic implantable cardioverter/ defibrillator, single, dual or biventricular		9.06
5071	Insertion or replacement of permanent pacemaker with transvenous electrode(s); single chamber .		9.04
5072	Insertion or replacement of permanent pacemaker with transvenous electrode(s); dual chamber.		9.04
5073	Insertion or replacement of pacemaker pulse generator only; single chamber atrial or ventricular		9.04
5074	Insertion or replacement of pacemaker pulse generator only (includes defibrillator pulse generator); dual chamber		9.04
5076	Insertion, replacement or repositioning of permanent transvenous electrode(s) only (15 days or more after initial insertion); single chamber.		
5077	Insertion, replacement or repositioning of permanent transvenous electrode(s) only (15 days or more after initial insertion); dual chamber.		

Percutaneous

5101	Coronary angioplasty, single or multiple vessel(s), with or without angiography with or without pacing		
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		
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		
5115	Percutaneous transcatheter closure of congenital interatrial communication (i.e. Fontan fenestration, atrial septal defect) with implant, including right heart catheterisation.	Daycare	
5116	Transcatheter placement of a drug eluting stent, percutaneous, with or without other therapeutic intervention, with or without angiography, any method, single vessel		
5117	Transcatheter placement of drug eluting stents, percutaneous, with or without other therapeutic intervention, with or without angiography, any method, more than one vessel		
5119	Percutaneous transcatheter closure of congenital ventricular septal defect with implant including right heart catheterisation.		
5133	Transcatheter aortic valve implantation (TAVI) for aortic stenosis (Edwards Sapien)	I.P.	9.02
5091	Cardioversion Daycare		

Paediatric Cardiology

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
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.	Side room, Diagnostic, Service	9.09
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	Side room, Diagnostic, Service	
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.	Side room, Diagnostic, Service	9.09
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	
5093	Paediatric cardiac catheterisation (left, right or both sides)	Diagnostic	
5094	Paediatric cardiac catheterisation and cardiac angiography combined	Diagnostic	
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	Side room, Diagnostic, Service	

CARDIOLOGY PROCEDURES - PAYMENT RULES

9.01	Please confirm which of the following conditions are met for • 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 findings in exercise echocardiography indicating myocardial ischemia. • 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.
9.02	For patients with aortic stenosis for whom surgical aortic valve replacement is considered unsuitable Clinicians wishing to undertake TAVI for aortic stenosis in patients who are at high risk for surgical valve replacement should ensure that patients understand the risk of stroke and death, and the uncertainty about the procedure's efficacy in the long term. Provide them with clear written information. In addition evidence of patient selection should be carried out by a multidisciplinary team including interventional cardiologists, cardiac surgeons, a cardiac anaesthetist and an expert in cardiac imaging. The multidisciplinary team should determine the risk level of each patient and must be named in the request for approval. TAVI may only be performed only by clinicians and teams with special training and experience in cardiovascular interventions and in units undertaking which have both cardiac and vascular surgical support for emergency treatment of complications. Such facilities must request approval from Irish Life Health for inclusion on the Irish Life Health list of such facilities.
9.03	• 5108 or 5008 is not payable in addition to 5109. • 5109 is not claimable when performed intraoperatively
9.04	Includes repositioning or replacement in the first 14 days after the insertion (or replacement) of the device.
9.05	Payable in full when carried out with: 5028, 5071,5072, 5073, 5074, 5076, 5077, 5201 and 5202
9.06	Please specify whether Single / Dual or Bivent. Please indicate which of the following conditions are met on the claim form: • 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. • Structural heart disease and spontaneous sustained VT, whether hemodynamically stable or unstable. • Syncope of undetermined origin with clinically relevant, hemodynamically significant sustained VT or VF induced at EP study. • LVEF <35% due to prior MI who are at least 40 days post MI and are in NYHA functional Class 1 or 2. • Non ischemic DCM who have LVEF <35% and who are NYHA functional Class 2 or 3. • 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. • Sustained VT and normal or near normal ventricular function. • HCM with one or more risk factors for SCD. • Prevention of SCD in patients with ARVD/C who have had one or more factors for SCD. • To reduce bet blockers in patients with long QT syndrome who are experience syncope and/or VT receiving beta blocker • Non-hospitalised patients awaiting transplantation • Patients with Brugada syndrome who have had syncope. • Brugada syndrome with documented VT that has not resulted in cardiac arrest. • Catecholamingic polymorphic VT with syncope and/or documented sustained VT while receiving beta blockers. • Cardiac sarcoidosis, giant cell myocarditis or Chagas disease

9.08	Benefit is payable for • Patients with a history of syncope who have recurrent but infrequent syncopal episodes, and when the aetiology of syncope has not been diagnosed by conventional means. Syncope is defined as a sudden but transient total loss of consciousness with spontaneous resolution. • 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.
9.09	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.

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Urology

Bladder

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
836	Bladder, instillation of anticarcinogenic agent (Mitomycin C)	Side Room	
839	Bladder, instillation of therapeutic agent for interstitial cystitis	Side Room, Service	
843	Bladder, instillation of anticarcinogenic agent (BCG medac)	Side Room	
844	Trials of micturition for urinary retention post-surgery.	I.P., Daycare 11.01	
850	Bladder neck, transurethral resection of		
855	Primary transurethral resection of bladder tumour(s), one or more (for diathermy of, use 885)		
865	Cystectomy, partial		
875	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis		
877	Cystectomy, complete, with continent diversion, any technique, using any segment of small and/or large bowel to construct neobladder		
878	Appendico-vesicostomy (Mitrofanoff procedure)		
879	Cutaneous vesicostomy (I.P.)	I.P.	
881	Cystoscopy with removal of JJ stent	Daycare	
882	Cystoscopy, with or without biopsy, including stress testing for female stress urinary incontinence or male post prostatectomy incontinence.	I.P., Daycare	
883	Cystoscopy with or without biopsy, with prostatic biopsy (I.P.)	I.P., Diagnostic, Daycare	
884	Cystoscopy with or without biopsy (I.P.)	I.P., Diagnostic, Daycare, MAC	
885	Cystoscopy with diathermy to bladder tumour(s) (I.P.)	I.P., Daycare	
887	Cystoscopy with insertion of JJ stent		
888	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds		
889	Cystourethroscopy with resection or fulguration of ectopic ureterocele(s) unilateral or bilateral in paediatric cases		
890	Cystoscopy with ureteric catheterisation (I.P.)	I.P., Diagnostic, Daycare	
891	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (e.g., balloon dilation, laser, electrocautery and incision)		
895	Cystoscopy with ureteroscopy and removal of ureteric calculus (I.P.)	I.P.	
896	Change of cystostomy tube (I.P.)	I.P., Side Room	
897	Cystolithotomy		
898	Percutaneous suprapubic cystostomy (I.P.)	MAC 11.02	
899	Substitution cystoplasty		
901	Closure of ruptured bladder (intraperitoneal)		
906	Augmentation cystoplasty		
907	Bladder neck, transurethral incision of		
908	Excision of ureterocele in children including reconstruction and repair of sphincters including reimplantation of ureters		
910	Excision of bladder diverticulum		
924	Litholapaxy	1 Night Only	
960	Open suprapubic cystostomy (I.P.)	I.P.	
1029	Complex uroflowmetry (using calibrated electronic equipment); for evaluation of bladder outlet obstruction and uncomplicated urge incontinence with or without ultrasound, with post void residual ultrasound screening in an Irish Life Health approved hospital Urodynamic laboratory	Side Room	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
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 Irish Life Health approved hospital Urodynamic laboratory	Side Room	
4645	Closure of bladder exstrophy		
4691	Young - Dees operation		
5845	Ileal conduit and bowel anastomosis		
846	Botulinum toxin injection to bladder wall only for idiopathic or neurogenic detrusor overactivity in patients who have not responded to conservative treatments (maximum of one injection payable per 9 month period since the last injection)	I.P., Daycare, Service, MAC	

Kidney

915	Embolisation of haemangioma of kidney		
916	Laparoscopy, partial nephrectomy		
917	Laparoscopy, radical nephrectomy		
918	Laparoscopy, surgical, nephrectomy, with total ureterectomy		
919	Laparoscopy, surgical, nephrectomy, including partial ureterectomy		
920	Nephrectomy, partial		
921	Radical nephrectomy (includes adrenalectomy and para-aortic lymph nodes)		
922	Radical nephrectomy including caval extension above and/or below liver		
923	Kidney transplant		
925	Simple nephrectomy		
930	Nephrolithotomy		
931	Percutaneous nephrolithotomy		
933	Percutaneous nephrolithotomy stag-horn calculus		
934	Percutaneous nephrostomy with or without antegrade pyelogram or stent placement		
936	Percutaneous tract formation for renal stone removal by another consultant (I.P.)	I.P.	
937	Living donor nephrectomy		
938	Nephrectomy with total ureterectomy and bladder cuff, through same incision		
939	Nephrectomy with total ureterectomy and bladder cuff, through separate incisions		
940	Pyelolithotomy		
941	Percutaneous nephrolithotomy, pelvic or calyceal involving contact lithotripsy		
945	Pyeloplasty		
946	Pyeloplasty, complicated (congenital kidney abnormality secondary pyeloplasty, solitary kidney, calycoplasty) neonate up to one year of age		
947	Radical nephrectomy in children (e.g. Wilms tumour) with contralateral exploration		
948	Laparoscopy, surgical; pyeloplasty		
955	Renal biopsy (needle)	Diagnostic	
956	Renal cyst puncture and aspiration		
5911	Ureteroscopy & contact lithotripsy with placement/removal of J stent, one or more sessions per hospital stay (I.P.)	I.P.	
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		11.03
59102	Extracorporeal Shock Wave Lithotripsy (ESWL) - as directed and prescribed by a Consultant Urologist for urinary tract stone(s), who has interpreted the relevant radiological tests/ scans and where the consultant is not present for the duration of the treatment		11.03
59103	Intra Renal flexible ureterorenoscopy for Intra renal stones	Day Care	11.04

Genital Tract

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
645	Epididymectomy, unilateral (I.P.)	I.P., Daycare	
655	Hydrocelectomy, bilateral (I.P.)	I.P., 1 Night Only	
660	Hydrocelectomy, unilateral (I.P.)	I.P., 1 Night Only	
669	Orchidectomy, radical, for cancer, inguinal approach		
670	Orchidectomy, bilateral (I.P.)	I.P.	
671	Subcutaneous testosterone implantation for hypogonadotrophic hypogonadism	Side Room	
672	Drainage of intra-scrotal abscess (I.P.)	I.P.	
673	Orchidectomy, radical, for cancer, inguinal approach including artificial prosthesis		
674	Orchidectomy, radical, for cancer, with abdominal exploration		
675	Orchidectomy, unilateral (I.P.)	I.P.	
679	Orchidectomy, radical, for cancer, with abdominal exploration including artificial prosthesis		
681	Injection of corpora cavernosa with pharmacologic agent(s) (e.g. papaverine, phentolamine)	Side Room, Service	
683	Circumcision	Daycare	
684	Circumcision includes dissection of prepuce from glands in patients where histology confirms for BXO (Balantis Xerotica Obliterans). Full Histology report must accompany claim	I.P., Daycare	
685	Penis, amputation of, partial		
687	Penis, amputation of, total		
688	Biopsy of penis (I.P.)	I.P., Diagnostic, Daycare	
692	Excision of penile plaque with or without graft		
693	Nesbit procedure (plastic operation on penis to correct angulation)		
694	Removal of penile prosthesis		
695	Prepuce, dorsal incision of	Daycare	
696	Release of priapism (needle drainage)		
697	Excision of epididymal cyst(s), unilateral (I.P.)	I.P., Daycare	
698	Excision of epididymal cyst(s), bilateral (I.P.)	I.P., Daycare	
699	Epididymectomy, bilateral (I.P.)	I.P.	
704	Epididymovasostomy, bilateral		
714	Laparoscopy, orchidopexy for intra-abdominal testis	Daycare	
715	Orchidopexy, inguinal approach with or without hernia repair, unilateral (I.P.)	I.P., Daycare	
720	Orchidopexy, inguinal approach with or without hernia repair, bilateral (I.P.)	I.P., Daycare	
735	Orchidopexy, unilateral for torsion with exploration and/or fixation of opposite side		
736	Orchidopexy, abdominal approach for intra-abdominal testis	Daycare	
740	Testicular biopsy (needle) (I.P.)	I.P., Diagnostic, Daycare	
741	Testicular Biopsy (open surgical) (I.P.)	I.P., Diagnostic, Daycare	
742	Testicular prosthesis, insertion/ replacement/removal of, unilateral	Daycare	
743	Testicular prosthesis, insertion/ replacement/removal of, bilateral		
755	Varicocelectomy	Daycare	
992	Pubovaginal sling urethropexy with tension-free vaginal tape (TVT)	1 Night Only	
993	Vesico colic fistula, excision of, and sigmoid colectomy.		11.05

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
994	Pubovaginal sling with cystocele repair or rectocele repair		
997	Pubovaginal sling including cystocele and rectocele repair		
4681	Insertion of malleable penile prosthesis		11.06
4682	Insertion of inflatable penile prosthesis		11.07

Prostate

700	Transurethral prostatectomy		
701	Radical retropubic nerve sparing prostatectomy (includes bilateral pelvic lymph adenectomy with bladder neck reconstruction and anastomosis to the urethra)		
707	Laser (Green Light) vaporisation of prostate including control of post operative bleeding, complete (meatotomy, Cystourethroscopy, urethral calibration and/or dilation, internal uretherotomy and transurethral resection of prostate are included if performed	1 Night Only	
708	Open prostatectomy		
709	Laparoscopic surgical prostatectomy, retropubic radical, including nerve sparing (includes robotic assisted prostatectomy with the De Vinci Prostatectomy Radical system)		
713	Biopsy of prostate (perineal or transrectal) includes ultrasound guidance (I.P.)	I.P., Diagnostic, Side Room	
716	Laser enucleation of the prostate with morcellation including control of postoperative bleeding, complete (meatotomy, Cystourethroscopy, urethral calibration and/or dilation, internal uretherotomy and transurethral resection of prostate are included if performed)	1 Night Only	
717	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including image guidance under general anaesthetic Daycare		11.08

Ureter

973	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	Diagnostic, 1 Night Only	
974	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of urethral or renal pelvic tumour		
975	Open Ureterolithotomy		
981	Ureterolysis, unilateral, by Laparotomy approach		
982	Ureterolysis, bilateral, by Laparotomy approach	I.P.	
983	Ureteric reimplantation, unilateral for reflux, stricture or fistula (I.P.)	I.P.	
984	STING procedure (initial) for vesicoureteric reflux (initial)	I.P., Daycare	
986	Ureteric reimplantation, bilateral for reflux, stricture or fistula (I.P.)	I.P.	
987	STING procedure for vesicoureteric reflux (repeat)	Daycare	
995	Ureterostomy, unilateral		
996	Ureteric substitution (with bowel segment)		
998	Sling operation for the correction of male incontinence, without implant	I.P., 1 Night Only	11.09
1000	Ureterostomy, bilateral		
989	Sling operation for the correction of male incontinence, with synthetic implant (I.P.)	I.P., 1 Night Only	10.09

Urethra

664	Meatoplasty (for Meatotomy use code 665)	I.P., Daycare	
665	Meatotomy (I.P.)	I.P., Daycare	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
666	Urethroplasty for penile or bulbar urethral stricture		
667	Acute repair of rupture of membranous urethra		
668	Urethroplasty for repair of prostatic or membranous urethral stricture, complete procedure		
676	Removal of implanted inflatable urethral/bladder neck sphincter, including pump, reservoir and cuff (AUS)		
677	Hypospadias, MAGPI procedure	Daycare	
703	Insertion of an endo urethral stent for urethral stricture	Daycare	
1015	Urethral dilatation (I.P.)	I.P., Side Room	
1030	Optical urethrotomy	I.P., 1 Night Only	
1032	Implantation of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir and cuff (AUS)		
4660	Epispadias, reconstruction of urethra		
4670	Hypospadias, fistula closure		
4675	Hypospadias, reconstruction of urethra		
4676	One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap		

UROLOGY - PAYMENT RULES

11.01	Management of patient to include intravenous infusion of antibiotic, bladder instillation, removal of catheter and recatheterisation of failure to void as appropriate
11.02	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.
11.03	For procedure code 59101, 59102 where monitored anaesthesia is required, claims must be supported by a medical report from the consultant anaesthetist outlining the necessity for monitored anaesthesia
11.04	Must be in specially approved Irish Life Health facility by an approved Irish Life Health consultant specialised and trained in the procedure
11.05	For cystocele, see procedure code 2415 gynaecological operations section. For urethropexy for stress incontinence refer to procedure code 245 gynaecological operations section.
11.06	The use of such implants is limited to Consultant Urologists with supported specialised knowledge, skill and expertise / training in this area and who perform at 30 of these cases annually in any given hospital. The Clinical conditions considered appropriate for the use of such prosthesis are: Post radical prostatectomy, Post cystectomy, Post major Colonic / colorectal surgery, Post Radiotherapy / cancer treatment to penis / prostate, For persons suffering from confirmed prolonged Type 1 or type 2 diabetes which causes erectile dysfunction due to diabetic related complications, urethral injury, pelvic fracture causing urethral injury which leads to long term erectile dysfunction. Clinical Indicators : This is a 3rd line therapy following at least 3 years of erectile dysfunction following failure of oral medication prescribed by a Consultant Urologist and / or Consultant Psychiatrist and following failure (where appropriate) of the use of inter-cavernous injections and use of vacuum pump devices and Patients will also have undergone a prolonged course of psychological and psychotherapy 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).
11.07	The use of such implants is limited to Consultant Urologists with supported specialised knowledge, skill and expertise / training in this area and who perform at 30 of these cases annually in any given hospital. The Clinical conditions considered appropriate for the use of such prosthesis are: Post radical prostatectomy, Post cystectomy, Post major Colonic / colorectal surgery, Post Radiotherapy / cancer treatment to penis / prostate, For persons suffering from confirmed prolonged Type 1 or type 2 diabetes which causes erectile dysfunction due to diabetic related complications, urethral injury, pelvic fracture causing urethral injury which leads to long term erectile dysfunction. Clinical Indicators: This is a 3rd line therapy following at least 3 years of erectile dysfunction following failure of oral medication prescribed by a Consultant Urologist and / or Consultant Psychiatrist and following failure (where appropriate) of the use of inter-cavernous injections and use of vacuum pump devices and Patients will also have undergone a prolonged course of psychological and psychotherapy 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)
11.08	Conditions of payment for code 717 are as follows: • At least two previous negative extended prostate biopsies • Histologic evidence of atypia on prior prostate biopsy • Histologic findings of high-grade prostatic intraepithelial neoplasia (PIN) on prior biopsy
11.09	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

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Vascular Procedures

Endovascular

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1419	Transluminal dilation of iliac vessels with or without stent or graft		
1421	Transluminal dilation with or without stent of carotid vessels		
1422	Transluminal dilation with or without stent or graft of femoral vessels		
1423	Transluminal dilation with stent of distal vessels		
1424	Transluminal dilation of distal vessels		
1417	In cases where angiography is performed during the procedures 1308, 1419, 1421, 1422, 1423 and 1424. Payable at 100%		

Head Neck and Upper Limbs

1250	Arterial biopsy (temporal artery, biopsy, bilateral under local anaesthetic)	Diagnostic, Side Room	
1290	Ligation of major vessels		
1459	Subclavian to branchial bypass or endarterectomy		
1461	Repair of subclavian aneurysm		
1462	Brachial embolectomy		
1463	Repair or bypass of brachial to radial or ulnar vessel, any method including harvesting of graft material		
1464	Repair of trauma to brachial artery with endarterectomy patch or bypass		
820	Arteriovenous anastomosis in arm		

Lower Limbs

1280	Common femoral artery embolectomy		
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)		11.01
1467	Femoral to popliteal bypass, above knee vein		
1468	Femoral to popliteal bypass, above knee synthetic		
1469	Femoral to popliteal bypass, below knee vein		
1471	Femoral to popliteal bypass, below knee synthetic		
1472	Profundaplasty with or without patch or endarterectomy		
1473	Common femoral artery endarterectomy		
1474	Repair of femoral artery aneurysm		
1476	Popliteal artery embolectomy		
1477	Tibial artery embolectomy		
1478	Femoral tibial artery bypass, including tibial-peroneal and peroneal artery bypass, or other distal vessels		
1479	Popliteal aneurysm artery repair or bypass		
1481	Femoral/femoral bypass		
1482	Repair of femoral or popliteal vessels due to trauma		

Varicose Veins

1408	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed	I.P., Daycare	
1411	Endovenous radiofrequency ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; one leg	Daycare	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1412	Endovenous radiofrequency ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; both legs	Daycare	
1413	Endovenous laser ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; one leg Daycare		11.02
1414	Endovenous laser ablation therapy of incompetent veins, extremity, inclusive of all imaging guidance and monitoring, percutaneous; both legs Daycare		11.02
1430	Iliac or femoral veins - removal of thrombus		
1435	Inferior vena cava ligation/ clipping, with or without thrombus		
1450	Portosystemic shunt		
1455	Sclerosing operation on varicose vein(s), one leg (I.P.)	I.P., Side Room, Service	11.02
1460	Sclerosing operation on varicose veins, both legs (I.P.)	I.P., Side Room, Service	11.02
1465	Splenorenal anastomosis		
1490	Varicose veins, exploration and removal of thrombus, unilateral		
1493	Flush ligation of long saphenous vein at sapheno-femoral junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in leg; one leg	Daycare	
1494	Flush ligation of long saphenous vein at sapheno-femoral junction in both groins with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in both legs	Daycare	
1495	Varicose veins, exploration and removal of thrombus, bilateral		
1496	Flush ligation of long saphenous vein at sapheno-femoral junction in the groin with or without complete stripping plus ligation of the short saphenous vein at the sapheno-popliteal junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in one leg	Daycare	11.03
1497	Flush ligation of long saphenous vein at sapheno-femoral junction in the groin with or without complete stripping plus ligation of the short saphenous vein at the sapheno-popliteal junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in both legs	Daycare	11.03
1498	Flush ligation of long saphenous vein at sapheno-femoral junction with or without complete stripping; multiple incisions with avulsion and ligation of varicose veins in the other leg	Daycare	
1499	Flush ligation of short saphenous vein at sapheno-popliteal junction behind the knee with or without complete stripping; multiple incisions in calf with avulsion and ligation of varicose veins; one leg	Daycare	
1500	Venous pressure and blood volume studies	Diagnostic	
1501	Flush ligation of short saphenous veins at sapheno-popliteal junctions behind both knees with or without complete stripping; multiple incisions in both calves with avulsion and ligation of varicose veins in both legs	1 Night Only	
1502	Ligation of single varicose vein in thigh or calf (I.P.)	I.P., Side Room	
1503	Ligation of multiple varicose veins one or both legs (I.P.)	I.P., Daycare	
1526	Stab avulsion of varicose vein(s), one leg (I.P.)	I.P., Side Room	
1527	Stab avulsion of varicose vein(s), both legs (I.P.)	I.P., Side Room	

Vascular Surgery

1409	Aorta bi-iliac bypass for atherosclerosis or aneurysm; endovascular (using prosthesis) (I.P.)	I.P.	
1305	Renal stenosis, repair of		
1306	Transcatheter embolisation, extremity, arteriovenous malformation (AVM) (I.P.) I.P.		
1307	Transcatheter removal of intravascular thrombus or foreign body		

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	
1401	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta		
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)		
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)		
1404	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, using aorto-aortic tube prosthesis		
1416	Thrombin injection into groin for pseudoaneurysm (including ultrasound guidance)		
1427	Supra-renal aneurysm repair		
1428	Repair of supra-renal aortic aneurysm rupture		
1429	Tube graft repair of abdominal aorta		
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.	
1432	Aorto bi-iliac bypass for atherosclerosis or aneurysm (IP)	I.P.	
1433	Aorto-femoral or bifemoral bypass for atherosclerosis or aneurysm (IP)	I.P.	
1434	Endarterectomy of abdominal aorta and iliac vessels		
1436	Repair of ruptured iliac artery aneurysm		
1437	Endarterectomy of iliac vessels alone		
1438	Visceral artery repair, re-anastomosis or endarterectomy		
1439	Renal artery anastomosis, endarterectomy or re-implantation or bypass		
1441	Embolectomy of visceral branches, superior mesenteric or renal arteries		
1442	Removal of infected aortic prosthesis		
1443	Obturator bypass from aorta or iliac to profunda or distal femoral bypass		
1444	Repair of abdominal aortic trauma		
1446	Aortic exclusion by axillo-femoral bypass		
1447	Endarterectomy of internal/external common carotid artery with or without patch graft, with or without shunt		
1449	Vertebral artery bypass or repair		
1451	Open repair of subclavian artery		
1452	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis; autogenous or non-autogenous graft		
1453	Arteriovenous anastomosis, open by basilic vein transposition		
1454	Translocation of common carotid to subclavian artery		
1456	Carotid subclavian bypass		
1457	Subclavian/subclavian bypass		
1458	Thoracotomy with repair of vessels of arch of aorta		

VASCULAR PROCEDURES - PAYMENT RULES

11.01	Payable in full with code for main procedure
11.02	The treatment of spider/thread veins and telangiectasia are specifically excluded from benefit
11.03	Documentation must be provided in order to support incompetence of the short saphenous vein. The Doppler scan report must therefore be attached to the claim form.

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Dental/Oral Surgery

Dental / Oral Surgery

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
3032	Removal of an impacted or unerupted tooth in a patient 16 years or younger under general anaesthetic	Daycare, Pre-Auth	13.01
3033	Removal of two impacted or unerupted teeth in a patient 16 years or younger under general anaesthetic	Daycare, Pre-Auth	13.01
3034	Surgical removal of odontoma(s) in a patient 16 years or younger under general anaesthetic	Daycare	13.01
3036	Open surgical exposure of a single impacted tooth in compact bone in patients 16 years or younger	Daycare	13.01
3037	Open surgical exposure of two teeth in compact bone in patients 16 years or younger	Daycare	13.01
3011	Temporomandibular joint, reconstruction osteotomy of ramus and joint with costochondral graft	I.P.	
3012	Temporomandibular joint, open surgical correction of dislocation	I.P.	
3013	Le Fort I osteotomy (includes segmental or cleft) with or without graft		
3014	Le Fort II osteotomy (includes via bicoronal flap) with or without graft		
3016	Osseointegrated mandibular implant including second stage abutment installation	Side Room, Pre-Auth	13.02
3017	Two osseointegrated mandibular implants including second stage abutment installation	Side Room, Pre-Auth	13.02
3018	Three osseointegrated mandibular implants including second stage abutment installation	Side Room, Pre-Auth	13.02
3019	Four osseointegrated mandibular implants including second stage abutment installation	Side Room, Pre-Auth	13.02
3020	Simple cysts or epulis, palate or floor of mouth, excision of	Side Room	
3021	Five osseointegrated mandibular implants including second stage abutment installation	Side Room, Pre-Auth	13.02
3022	Six or more osseointegrated mandibular implants including second stage abutment installation Side Room, Pre-		
Auth 13.02			
2930	Buried tooth roots, (includes more than one root) of one tooth, removal of Side Room, Pre-Auth	13.03	
2935	Buried tooth roots, (multiple) of teeth, removal of	Daycare, Pre-Auth	13.03
2940	Dental cysts of maxilla or mandible	Daycare	13.04
2950	Extraction of teeth (more than six permanent teeth) with or without alveolectomy	Side Room	
2953	Gingivectomy, one to four teeth	Side Room, Pre-Auth	13.05
2954	Gingivectomy, five to eleven teeth	Side Room, Pre-Auth	13.05
2956	Gingivectomy, twelve or more teeth	Side Room, Pre-Auth	13.05
2973	Removal of one upper impacted or unerupted tooth	Daycare, Pre-Auth	
2974	Removal of two upper impacted or unerupted teeth	Daycare, Pre-Auth	
2976	Removal of one lower impacted or unerupted tooth	Side Room, Pre-Auth	
2977	Removal of two lower impacted or unerupted teeth	Daycare, Pre-Auth	
2978	Removal of one impacted or unerupted canine tooth	Daycare, Pre-Auth	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2979	Removal of two impacted or unerupted canine teeth	Daycare, Pre-Auth	
2980	Labial frenectomy with dissection of tissue	Side Room	
2981	Removal of four or more impacted or unerupted teeth	Daycare, Pre-Auth	
2982	Removal of three impacted or unerupted teeth which includes two lower teeth	Daycare, Pre-Auth	
2983	Removal of three impacted or unerupted teeth which includes two upper teeth	Daycare, Pre-Auth	
2984	Removal of one upper and one lower impacted or unerupted tooth	Daycare, Pre-Auth	
2985	Odontoma, excision of	I.P., Daycare	
2996	Periodontal mucoperiosteal flap surgery, one to four teeth	Side Room, Pre-Auth	13.06
2997	Periodontal mucoperiosteal flap surgery, five to eleven teeth Side Room, Pre-Auth	13.06	
2998	Periodontal mucoperiosteal flap surgery, twelve or more teeth Side Room, Pre-Auth	13.06	
3001	Surgical exposure and repositioning of an impacted tooth	Daycare, Pre-Auth	
3002	Surgical exposure and repositioning of impacted teeth	Daycare, Pre-Auth	
3005	Root resection or apicectomy, single, with or without cyst removal and apical curettage	Side Room	
3010	Root resection or apicectomy, multiple, with or without cyst removal and apical curettage	Side Room	
3015	Reimplantation of tooth in socket with splinting	Side Room	
3025	Small tumours of dental origin, removal of, includes biopsy	Side Room	
3024	Le Fort III osteotomy via bicoronal flap with or without graft with Le Fort I		
3026	Reconstruction midface, osteotomies (other than Le Fort I type) and bone grafts (includes obtaining autografts) (includes via bicoronal flap)		
3027	Sagittal split osteotomy with or without graft		
3028	Vertical ramus osteotomy, intraoral or extraoral with or without graft		
3029	Zygomatic osteotomy, unilateral		
3031	Osteotomy segmental of maxilla and mandible		
3030	Tuberosities, reduction of	Side Room	

DENTAL/ORAL SURGERY - PAYMENT RULES

13.01	Payable to Consultant Maxillofacial Surgeon and Oral Surgeon/Orthodontist on the Specialist Register maintained by the Dental Council and approved Periodontists
13.02	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 exceptional circumstances. In addition, a grant-in-aid of EUR532.29 is payable per implant towards the cost of the implant components.
13.03	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.
13.04	Cystic tissue removed in the process of tooth or root resection and extractions, surgical or otherwise, is considered to be an integral part of that surgical treatment and is not a separate procedure.
13.05	Gingivectomy is taken to include the removal of surface deposits from the roots. For codes 2953, 2954, and 2956 benefit is only approved in cases of severe gingival hyperplasia and which, in the opinion of Irish Life Health's dental advisors, are not treatable by conservative methods. Prior notification including full clinical details, radiographs, or if more appropriate, photographs and pocket depths, should be sent to Irish Life Health for this purpose. It is necessary to provide the deepest pocket depth for each tooth involved in gingival/periodontal surgery on the pocket depth chart in order to have pre certification approval.
13.06	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 Irish Life Health. However, in exceptional cases, where serious periodontal disease is present which, in the opinion of Irish Life Health's dental advisors, is not treatable by conservative methods and where pocket depths are 6mm or more, Irish Life Health will consider such cases for payment. Prior notification, including full clinical details, relevant radiographs and pocket depths, should be sent to Irish Life Health for this purpose. It is necessary to provide the deepest pocket depth for each tooth involved in gingival/periodontal surgery on the pocket depths chart in order to have precertification approval.

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Radiotherapy

Radiotherapy Patient Treatment Management Programme
Consultant day care radiation oncology comprehensive benefit services including, clinical treatment, planning, manual design, simulation, tumour localisation, treatment volume determination, treatment time/ dosage determination, choice of treatment modality, determination of number and size to 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 required.

The benefits listed in the Radiotherapy section of the schedule are inclusive of all forms of imaging guidance evaluation through the radiotherapy treatment session, except as otherwise stated.

The benefit levels are site specific. However, if the site is not shown below then please claim under code 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 Side Room basis. However, the same rates apply when it is medically necessary to admit a patient.

Radical Course (Site Specific)

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5626	Breast		
5704	Breast (bilateral)		
5627	Prostate		
5628	Rectum		
5629	Brain		
5631	Gynaecological (cervix; endometrium; vulva; vagina; ovaries)		
5632	Oesophagus, pre operative radiation		
5633	Oesophagus, primary radiation therapy (Oesophagus not surgically removed)		
5634	Stomach		
5636	Anal Canal		
5637	Pancreas Post Operative		
5638	Pancreas, primary radiation therapy (Pancreas not surgically removed)		
5639	Lymphoma		
5641	Sarcoma		
5642	Skin		

Radical Course (Not Specific - for sites not listed)

5643	Simulation and treatment planning (standard) less than 15 treatments		
5644	Simulation and treatment planning (standard) 16 to 25 treatments		
5646	Simulation and treatment planning (standard) 26 to 30 treatments		
5647	Simulation and treatment planning (standard) 31 to 35 treatments		
5648	Simulation and treatment planning (intermediate) less than 15 treatments		
5649	Simulation and treatment planning (intermediate) 16 to 25 treatments		
5651	Simulation and treatment planning (intermediate) 26 to 30 treatments		
5652	Simulation and treatment planning (intermediate) 31 to 35 treatments		
5653	Simulation and treatment planning (3 dimensional) 16 to 25 treatments		
5654	Simulation and treatment planning (3 dimensional) 26 to 30 treatments		
5656	Simulation and treatment planning (3 dimensional) 31 to 35 treatments		
5681	Simulation and treatment planning (3 Dimensional) less than 15 treatments		

Radiological Guidance

5734	Radiological imaging IGRT; KV and MV imaging during a radical course of IMRT radiotherapy only where fiducial markers have been placed.		14.01
5738	Radiological imaging IGRT; in conjunction with external beam treatments where fiducial markers have been placed		14.01

Intensity Modulated Radiotherapy Plan

5733	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications		14.01

High Dose Radiation (HDR)

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5659	Brachytherapy - High Dose Radiation, Intracavitary cylinder insertion non operative; insertion of a single applicator without the need for operative placement, all inclusive benefit for applicator placement and plan generated for each treatment. All inclusive benefit for multiple treatment fractions. The benefit includes one follow-up outpatient consultation.		
5661	Brachytherapy - High Dose Radiation, Intracavitary gynaecological device inserted in theatre. Insertion of more than one applicator (such as tandems and/or ovoids or ring for cervix, vagina, or uterine cavity brachytherapy). Generation of complex computerised plan with normal tissue dose determination, saggital, coronal and transverse slices generated. All inclusive benefit for multiple treatment fractions. The benefit includes one follow-up outpatient consultation after the course of treatment,		
5682	High dose radiation brachytherapy (HDR) gynaecological (no surgery case). Benefit includes placement of treatment applicators, computerised planning, dosimetry and brachytherapy treatment sessions. The consultant benefit for this code is claimable for each subsequent session during the patient's stay.		
5683	High dose radiation brachytherapy (HDR) Post hysterectomy. Benefit includes insertion of treatment applicators, computerised planning, dosimetry and brachytherapy treatment session. The consultant benefit for this code is claimable for each subsequent session during the patient's stay	Daycare	
5684	High dose radiation brachytherapy (HDR) to prostate, benefit includes computerised planning, dosimetry, placement of treatment applicators for temporary implants and treatment sessions. The benefit includes one follow-up outpatient consultation after the course of treatment.		
5686	High dose radiation brachytherapy(HDR) primary treatment for intact breast, benefit includes computerised planning, dosimetry, placement of treatment applicators and treatment sessions. The benefit includes one follow-up outpatient consultation after the course of treatment		
5687	High dose radiation brachytherapy(HDR) primary treatment post mastectomy, benefit includes computerised planning, dosimetry, placement of treatment applicators and initial treatment session.	Daycare	
5688	Subsequent brachytherapy (HDR)treatment session post mastectomy case	Daycare	
5689	High dose radiation brachytherapy interstitial,(e.g. head and neck), benefit includes computerised planning, dosimetry, placement of treatment applicators and treatment sessions. The benefit includes one follow-up outpatient consultation after the course of treatment		
5696	High dose radiation brachytherapy (HDR), bronchus, benefit for placement of treatment applicators, computerised planning, dosimetry and initial treatment session	Daycare	
5697	Subsequent brachytherapy (HDR) treatment session (bronchus)	Daycare	
5698	High dose radiation (oesophagus), all inclusive benefit for placement of treatment applicators, computerised planning, dosimetry and initial treatment session.	Daycare	
5701	Subsequent brachytherapy (HDR) oesophagus treatment session	Daycare	
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. - Radiologist benefit		

Interstitial Brachytherapy (Multiple)

5669	Interstitial brachytherapy for Breast		14.03
5671	Interstitial brachytherapy for Head & Neck		14.03
5672	Interstitial brachytherapy for Gynaecological		14.03
5673	Interstitial brachytherapy for Ano-rectal		14.03
5674	Interstitial brachytherapy for Sarcoma		14.03

Interstitial Needles Insertion for Brachytherapy (Once Only)

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5663	Interstitial needles insertion for Breast		14.04
5664	Interstitial needles insertion for Head & Neck		14.04
5666	Interstitial needles insertion for Gynaecological		14.04
5667	Interstitial needles insertion for Ano-rectal		14.04
5668	Interstitial needles insertion for Sarcoma		14.04

Intraluminal - Endobronchial - Oesophagus or Bile Duct

5662	Intraluminal - Endobronchial; oesophagus or bile duct.		14.05

Low Dose Rate - (LDR) Brachytherapy

5676	Intraoperative implantation of non cylinder intracavity device (to be read in conjunction with code 5677)		
5677	Brachytherapy planning review and treatment delivery LDR. Selectron, multiple treatment fractions		
5678	Interstitial iridium needles insertion (LDR), including tube placement in theatre under anaesthetic, manual placement of each needle, dose calculations and material preparation		

Other

5709	Required course of radiotherapy for patients with symptoms of rejection of a major transplanted organ(s) e.g. heart/lung		

Paediatric anaesthetic Benefit for Radiotherapy

5966	General anaesthetic for mould making in preparation for radiotherapy, in children under 16 years of age		
5967	General anaesthetic for simulator mapping for radiotherapy in children under 16 years of age, one or more sessions		
5968	General anaesthetic for radiotherapy treatment in children under 16 years of age, per session		

Palliation Course

5657	Palliation 5 or less fractions		
5658	Palliation 6 or more fractions		

Prostate

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 cystoscopy. Radiotherapist benefit		14.08
5727	Detailed prostate tumour and prostate volume 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		14.08
5995	Transrectal ultrasound for detailed prostate tumour and prostate volume estimation includes modelling and planning for 3-D template guidance for stage two procedure. Radiologist benefit		14.08

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5996	Transrectal and fluoroscopic guidance during second stage procedure of placement of radioactive seeds in prostate includes accurate calibration for template guidance; benefit includes follow-up CT pelvic examination. Radiologist benefit.		14.08, 14.09
5997	Detailed prostate volume study under anaesthesia includes tumour and prostate volume estimation; modelling and planning, patient consultation, with or without digital rectal examination. Radiotherapist benefit.	I.P.	14.08

Radiopharmaceutical Therapy

1158	Initial consultation and planning on an outpatient basis followed by hospital side room admission for radiopharmaceutical therapy (I-131) hyperthyroidism on a subsequent day	Side Room	
1159	Initial consultation and planning on an outpatient basis followed by hospital admission for radiopharmaceutical (I-131) ablation of gland for thyroid carcinoma on a subsequent day		

Surface Application Mould

5679	Surface application Brachytherapy, planning review and application of treatment - per treatment		

Total Body Irradiation

5989	Total body irradiation.		

Stereotactic Radiosurgery

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-Auth	14.12
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-Auth	14.12
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. Radiotherapists Benefit		
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. Neurosurgeon's Benefit		
5992	All inclusive benefit for Stereotactic radiosurgery (linear accelerator) for arteriovenous malformations, acoustic neuromas and deep seated tumours 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. Radiotherapists Benefit		
5994	All inclusive benefit for Stereotactic radiosurgery (linear accelerator) for arteriovenous malformations, acoustic neuromas and deep seated tumours 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. Neurosurgeon's Benefit		

RADIOTHERAPY - PAYMENT RULES

14.01	Benefit payable in full (once only) with the code for the specific radiotherapy course.
14.03	Generation of complex computerised plan or CAT planning with homogeneity criteria assessment/ minimum-maximum point assessment and Brachytherapy treatment. Removal of needles when course is completed.
14.04	Insertion of needles into tumour(s) necessitating a surgical procedure in theatre under anaesthetic.
14.05	Insertion of applicator in theatre.
14.08	Clinical Indications for the prostate brachytherapy procedure codes 5726, 5727, 5996 and 5997 are for patients with the following: • PSA < 20ng/ml • Prostate mass < 50cc • Gleason score < 8
14.09	Benefit for code 5996 is payable in full when performed during the same theatre session as code 5995
14.12	• Small symptomatic arterio-venous malformations < 3cm. • Trigeminal neuralgia following referral by a consultant neurologist and when the condition had persisted for at least 6 months despite conservative treatment with pharmacotherapies (carbamazepine, phenytoin and baclofen) or the member is unable to tolerate the side effects of the medications. • Meningioma's, excluding the initial treatment of those with a cortical or spinal location. • 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 limitations to the spine. Benefit will only be provided following a multi-disciplinary team meeting at a nominated Irish Life Health hospital, where such team includes the attendance of a neuro-radiation oncologist.

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Pain Medicine

Pain Medicine

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5044	Revision including replacement, when performed, or re-positioning of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s); includes fluoroscopy	I.P., Daycare	
5051	Replacement of spinal neurostimulator pulse generator or receiver direct or inductive coupling	I.P., Daycare	
5575	Injection of trigeminal ganglion via foramen ovale under image guidance(IP)	I.P., Side Room	
5580	Destruction by radiofrequency lesioning of trigeminal ganglion via foramen ovale under x-ray guidance via foramen ovale (IP)	I.P., Daycare	
5611	Transforaminal injection of anaesthetic agent, assessment of response and application of steroid if indicated to medial branch nerve or dorsal root ganglion at one or more levels under image guidance (IP)	I.P., Daycare, MAC	
5612	Pulsed radiofrequency (PRF) lesioning of medial branch nerve or dorsal root ganglion, one or more levels under image guidance with sensorimotor testing	I.P., Daycare, MAC	
5614	Peripheral nerve lesioning including pulsed radiofrequency or electrical stimulation (I.P.)	I.P., Side Room	
5615	Peripheral nerve block for pain control using nerve stimulator or ultrasound guidance	I.P., Side Room	
5616	Neurodestructive thermal rhizotomy (temperature > 69°C), under image guidance, with sensory and motor testing, one or more levels, lumbar, sacral or thoracic (IP)	I.P., Daycare, MAC	16.01
5617	Neurodestructive thermal rhizotomy (temperature >69°C), under image guidance, with sensory and motor testing, one or more levels, cervical(IP)	I.P., Daycare, MAC	16.01
5618	Repeat of procedure 5616 to the same anatomical site, one or more levels, lumbar, sacral or thoracic (I.P.)	I.P., Daycare	16.01
5619	Repeat of procedure 5617 to the same anatomical site, one or more levels, cervical (I.P.)	I.P., Daycare, MAC	16.01
5620	Sympathetic block, under image guidance(IP)	I.P., Side Room	
5621	Intravenous regional block/sympathectomy by Bier's technique	I.P., Side Room	
5719	Chemical sympathectomy, lumbar or coeliac plexus under image guidance (I.P)	I.P., Side Room	
5984	Insertion of spinal cord stimulator - trial stage	I.P., Pre-Auth	16.02
5999	Insertion of spinal cord stimulator - Implantation stage	I.P., Pre-Auth	16.02
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	
3541	Caudal epidural	I.P., Side Room	
5038	Refilling and maintenance of implantable pump or reservoir including access to pump port (I.P.)	I.P., Side Room	16.03
5039	Implantation of catheter system and reservoir; tunnelled, intrathecal or epidural catheter for long term medication administration via an external pump or implantable reservoir/infusion pump	I.P.	16.03
5042	Removal of subcutaneous implantable pump (does not apply to removal of CVC)	I.P., Side Room	
5043	Removal of spinal neurostimulator pulse generator or receiver, or neurostimulator electrode percutaneous array(s) or plate/paddle(s)(I.P.)	I.P., Daycare	
5057	Insertion of neurostimulator pulse generator and electrodes: sacral nerve for bladder muscle control: permanent implantation.		
	I.P., Pre-Auth, 1 Night Only	16.04	
5056	Insertion of neurostimulator pulse generator and electrodes: sacral nerve for bladder muscle control: trial stage	I.P., Daycare, Pre-Auth	16.05

PAIN MEDICINE - PAYMENT RULES

16.01	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 i.e.. 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.
16.02	Benefit for the insertion of spinal cord stimulators will be subject to the following criteria being satisfied: Whether or not low or High Frequency spinal cord stimulator is used must be specified on the claim form • Prior approval is sought by a Consultant recognised by Irish Life Health and who also has a Diploma in Pain Medicine. • The procedure is performed in a hospital that is listed in the Irish Life Health Directory of Hospitals, and • 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 • 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 • 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 Irish Life Health in advance of treatment
16.03	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

16.04	Conditions of payment for procedure code 5057 are as follows: • 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. • Treatment of non-obstructive urinary retention provided test stimulation of the patient satisfies the criteria indicating at least 50% decrease in residual urinary volume.
16.05	• 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 (the frequency and/or severity of symptoms 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 (e.g. pelvic floor exercises, bio feedback and fluid management) and related activities have failed. • Treatment of non-obstructive urinary retention when all of the following criteria are met: (a) the member has experienced urinary retention for at least 12 months and the condition has resulted in significant disability (this frequency and/or severity of symptoms are limiting the members ability to participate in activities of daily living) and (b) Pharmacotherapies (e.g. beta blockers and cholinergics, anti biotics for urinary tract infections) as well as intermittent catheterisation have failed or are not well tolerated.

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Skin and Subcutaneous Tissue

Abscess

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1560	Incision and drainage of pilonidal abscess	1 Night Only	
1663	Drainage of abscess or haematoma, (deep tissues) requiring general anaesthetic		

Destruction

1587	Laser treatment to port wine stains only, one or more sessions, plus photographic evidence to be supplied with claim	Outpatient, Consultant fee remains direct settlement	
15871	Laser treatment to port wine stains only, one or more sessions, under General Anaesthesia, plus photographic evidence to be supplied with claim	Daycare	

Excisions

405	Destruction of lesion(s) by any method, genital/anal warts (e.g. condyloma, papilloma, molluscum contagiosum, herpetic vesicle) where performed under General anaesthetic in an Irish Life Health approved hospital (I.P.)	I.P., Side Room/ Outpatient, Service	15.28
1505	Abscess, cyst or tumour, aspiration of (I.P.)	I.P., Side Room/ Outpatient, Service	15.28
1507	Angioma of skin and subcutaneous tissue or mucous surfaces, excision and repair of, under general anaesthetic	Daycare	
1509	Biopsy of skin, subcutaneous tissue and/or mucous membrane, any method (e.g. punch, incision or shave), including simple closure; single lesion	I.P., Diagnostic, Service, Side Room/ Outpatient	15.28
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., Service, Side Room/ Outpatient	15.28
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., Service, Side Room/ Outpatient	15.28
1525	Foreign body, removal of	Side Room/ Outpatient	15.28
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)	I.P., Side Room, Diagnostic, Service	
1540	Skin abscess, (superficial) incision and drainage of (I.P.)	Side Room/ Outpatient	15.28
1546	Enucleation or excision of lipoma	Side Room/ Outpatient	15.28
1550	Malignant melanoma, wide excisional biopsy	Side Room	15.01
1551	Malignant melanoma, wide excisional biopsy with flap or graft repair	Daycare	15.02
1552	Surgical excision of benign lesion or lesions (includes sebaceous cysts) (I.P.)	I.P., Service, Side Room/ Outpatient	15.28
1554	Surgical excision of benign lesion or lesions of face (includes sebaceous cysts) (I.P.)	I.P., Service, Side Room/ Outpatient	15.28

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1561	Pilonidal sinus or cyst, excision of	Daycare	
1562	Pilonidal Sinus, excision of, with Rhomboid flap/Z-plasty for closure of large defect; multiple layer closure	1 Night Only	
1575	Basal cell carcinoma/squamous cell carcinoma- simple excision Side Room, Service 15.01		
1576	Basal cell carcinoma/squamous cell carcinoma, excision and graft or local flap	Side Room, Service	15.02, 15.04
1591	Hydradenitis suppurativa, excision and suture	Side Room	
1592	Hydradenitis suppurativa, excision and graft		
1593	Hydradenitis suppurativa, extensive debridement	Daycare	
1620	Complex wound(s) repair, (torn, crushed, deep) lacerations or avulsions requiring prolonged debridement and irrigation, extensive undermining and/or trimming of defect edges and multilayered closure (involving deeper layers in addition to skin closure) with or without stents or retention sutures.	I.P., Daycase, Service	
4210	Plantar warts, complete surgical excision, one or more (not local application, cryotherapy or curettage etc.)	Service, Side Room/ Outpatient	15.28
4947	Large lipoma > 4 cm in diameter, requiring removal under general anaesthetic, deep to deep fascia requiring surgery by Consultant Plastic Surgeon	1 Night Only	

Infusions and Other Therapies

55	Paracentesis abdominis with infusion of cytotoxic drugs		15.10, 15.11
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		
1528	Patch Testing - Consultant Dermatologist or Immunologist consultations on an Outpatient 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, Outpatient	
1529	Phototherapy - Consultant Dermatologist consultations on an out-patient basis for a patient receiving a course of phototherapy in a Irish Life Health approved hospital facility (list available on request from Irish Life Health). For procedure code 1529 maximum benefit of one payment per twelve month period	Service, Outpatient	
1571	Intravenous infusion of Ferinject (ferric carboxymaltose) for patients with resistant iron deficiency anaemia (maximum of two treatments per year)	Side Room	15.10, 15.11
1572	Intravenous infusion of Monover (iron isomaltoside) for patients with resistant iron deficiency anaemia	Side Room	15.10, 15.11
1594	Infusion of tocilizumab (RoActemra)	Side Room	15.10, 15.11
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	Side Room	15.10, 15.11, 15.12
1607	Intravenous infusion of Abatecept with methotrexate for the treatment of moderate to severe rheumatoid arthritis in adult patients, and moderate to severe active polyarticular juvenile idiopathic arthritis in paediatric patients six years of age and older, who have had an insufficient response or intolerance to other disease-modifying anti-rheumatic drugs including at least one tumour necrosis factor (TNF) inhibitor	Side Room	15.10, 15.11
1611	Intravenous infusion of Fabrazyme for patients with a confirmed diagnosis of Fabry's disease	Service, Side Room	15.10, 15.11

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1613	Intravenous infusion therapy for severe neurological disorders or auto-immune disease, not elsewhere specified and for Hurler's and Hunter's disease; by Consultant Neurologists, Immunologists, Rheumatologists, Haematologists, Nephrologists, Paediatricians, Respiratory Physicians, Gastroenterologists, General Physicians and Endocrinologists registered with Irish Life Health	Service, Side Room	15.10, 15.11
1614	Infusion of Mitoxantrone (Novantrone) for patients with secondary progressive multiple sclerosis, progressive-relapsing multiple sclerosis and worsening relapsing-remitting multiple sclerosis	Service, Side Room	15.10, 15.11
1623	Intravenous immunoglobulin for patients with myasthenia gravis, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy with conduction block and Guillain-Barre syndrome	Side Room	15.10, 15.11
1624	Intravenous infusion of zoledronic acid (zometa)	Side Room	15.10, 15.11, 15.13
1626	Insertion of tunnelled central venous access with externalized catheter end	Side Room	15.14, 15.15
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 (Independent procedure)	I.P., Daycare	15.14, 15.15
1629	Intravenous infusion of pamidronate (aredia) for	Side Room	15.10, 15..11, 15.16
1630	Exchange transfusion, blood; new-born		
1631	Hyperbaric oxygen therapy (HBOT)administered systemically in a pressurised chamber unit (not applicable for topical hyperbaric oxygen therapy such as limb encasing devices) initial, including full medical evaluation		15.17
1632	Hyperbaric oxygen therapy (HBOT) administered systemically in a pressurised chamber unit (not applicable for topical hyperbaric oxygen therapy such as limb encasing devices) subsequent, per session.		15.17
1633	Infusion of infliximab	Side Room	15.10, 15.18
1634	Placement of non tunnelled central venous catheter (peripherally or centrally inserted)	I.P., Side Room, MAC	15.14, 15.15
1635	Exchange transfusion (intra uterine)		
1636	Intravenous immunoglobulin for patients with a haematological malignancy or immune deficiencies	Side Room	15.10, 15.11
1637	Blood transfusion for patients with a haematological malignancy or immune deficiencies	Side Room	15.10, 15.11
1638	Intravenous antimicrobials for patients on cytotoxic chemotherapy regimens for malignant disease	Side Room	15.10, 15.11
1639	Electrolyte replacement for patients on cytotoxic chemotherapy regimens for malignant disease	Side Room	15.10, 15.11
1641	Therapeutic phlebotomy, by the consultant physician or under the consultant physician supervision, includes appropriate advice to the patient as necessary, including file report or report to the referring doctor	Side Room/ Outpatient	15.28
1642	Isolated limb perfusion including exposure of major limb artery and vein, arteriotomy and venotomy		
1643	Intravenous iron infusion for patients with resistant iron deficiency anaemia	Side Room	15.10, 15.11
1646	Plasmapheresis	Side Room	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
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	
4281	Bone marrow aspiration	Diagnostic, Side Room	
4282	Bone marrow biopsy	Diagnostic, Side Room	
4286	Bone marrow harvesting (I.P.)	I.P.	
4287	Bone marrow aspiration and biopsy	Diagnostic, Side Room	
4288	Peripheral blood stem cell harvesting (I.P.)	I.P.	
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		
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		
4296	Autologous bone marrow transplantation or blood derived peripheral stem cell transplantation, for patients with acute leukaemia, chronic leukaemia, non-Hodgkin's lymphoma, Hodgkin's disease or multiple myeloma; all inclusive benefit for in-patient and out-patient treatment for a three month period		
5985	Complete investigation of 'at risk' patients with allergy/anaphylaxis requiring food and drug challenge studies (I.P.)	I.P., Daycare, Service	15.2
1667	Aspirin desensitisation, to include all necessary sampling and monitoring of the patient during the procedure.	Daycare, Service	15.21
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 diseasemodifying anti-rheumatic drugs including one or more tumour necrosis factor (TNF) inhibitor therapies	Side Room	15.10, 15.11
1669	Infusion of Tysabri as a single disease modifying therapy in highly active relapsing remitting multiple sclerosis	Side Room, Pre-Auth	15.22
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	1 Night Only	
1573	Removal of tunnelled central venous catheter with subcutaneous access port under local anaesthetic, with or without sedation	Side Room, MAC	15.14, 15.15
1574	Insertion of tunnelled central venous catheter with subcutaneous access port	I.P., Side Room	15.14, 15.15

Medical Oncology

4298	High dose chemotherapy with autologous stem cell rescue, for children with high risk brain tumour: all inclusive benefits for in patient attendance, stem cell harvesting and chemotherapy; claimable once per treatment cycle		
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	Service, Side Room	15.26
1609	Consultation and assessment by a Consultant Medical Oncologist of a patient on a course of cytotoxic oral anti-cancer agents	I.P., Outpatient	15.24, 15.26

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1619	Supervision and management by a Consultant Oncologist/Haematologist of a patient who attends an oncology ward for Intravenous infusion of cytotoxic Chemotherapy	Service, Side Room	15.25, 15.26
16191	Sub-cutaneous Cytotoxic Chemotherapy (Where not otherwise specified)	Service, Side Room	15.25, 15.26
1677	Supervision and management by a Consultant of a patient receiving cytotoxic chemotherapy with Velcade or Vidaza by injection requiring monitoring in a hospital setting	Side Room	
1579	Supervision and management by a Consultant of a patient receiving intravenous infusion cytotoxic chemotherapy where the patient also receives a same day infusion of pamidronate or zoledronic acid, for patients with metastatic carcinoma	Side Room	15.26, 15.27

ONCOTYPE TEST (for women undergoing treatment for breast cancer)

Subject to Pre-Authorisation. Conditions as follows:

- Breast cancer is non-metastatic (node negative) and
- Breast tumour is oestrogen receptor positive and/or progesterone receptor positive; and
- Breast tumour is HER2/neu receptor negative; and
- Breast tumour size is 10.1 to 5.0 cm (or 0.5mm to 1 cm with unfavourable histological features); and
- Adjuvant chemotherapy is not precluded for any other factors (e.g. advanced age and/or significant co-morbidities)

MOHS Surgery

1581	Mohs micrographic technique, first layer (stage) for removal of lesions from head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves or vessels; 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)	Side Room	15.06, 15.08
1582	Each additional layer (stage) after the first layer (stage) claimed under 1581, up to 5 tissue blocks	Side Room	15.06, 15.08
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.	Side Room	15.06, 15.08
1584	Each additional layer (stage) after the first layer (stage) claimed under code 1583, up to 5 tissue blocks	Side Room	15.06, 15.08
1596	Each additional block after the first 5 tissue blocks, any layer (stage), (Benefit is payable in full in conjunction with 1581 to 1584)	Side Room, Pre-Auth	15.06, 15.08
1597	Repair by layered closure associated with Mohs surgery, head and neck, all sizes	Side Room	15.06, 15.07, 15.08
1598	Repair by layered closure associated with Mohs surgery, non-head and neck, all sizes	Side Room	15.06, 15.07, 15.08

Wounds

1601	Wounds up to 2.5cm in total length, suture or staple of lacerated or torn tissue, single or multi layered closure with or without irrigation or debridement.	I.P., Side Room/ Outpatient	15.05, 15.28

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1602	Wounds from 2.6cm to 7.5cm in total length, suture or staple of lacerated or torn tissue, single or multi layered closure with or without irrigation or debridement.	I.P., Side Room/ Outpatient	15.05, 15.28
1603	Wounds greater than 7.5cm in total length, suture or staple of lacerated or torn tissue, single or multi layered closure with or without irrigation or debridement.	I.P., Side Room	15.05.
1578	Wounds or ulcers requiring debridement when it is medically necessary to perform the procedure under general anaesthetic	I.P., Daycare, Service	

SKIN AND SUBCUTANEOUS TISSUE - PAYMENT RULES

15.05	For procedure code 1601, 1602, 1603, benefit includes wound closure by tissue adhesives (e.g. Two-cyanoacrylate) either singly or in combination with sutures or staples or in combination with adhesive strips. Wound closures utilising adhesive strips as the sole repair material may only be claimed under our Outpatient products.
15.06	**Moh's micrographic surgery** Mohs 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 are 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 in Mohs surgery is defined as an individual tissue piece embedded in mounting medium for sectioning (irrespective of the number of sections cut from the block for slice preparation). When Mons 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's surgery starts with code 1582 or 1584 but not code 1581 or 1583 because no debulking is necessary the second day. It may be necessary to sue 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, 1584 or 1596 is payable in full including multiples of codes 1582, 1584 and 1596. In exceptional cases where two distinctly separate tumours are removed during the same session full benefits are payable for the treatment of each separate tumour. Benefits listed apply to removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, histopathologic preparation and microscopic examination of specimens by the Mohs surgeon and also include simple single layer repair of the resultant defect.
15.07	If repair requiring adjacent tissue transfer or multi-layered closure (involving deeper layers in addition to epidermal and dermal closure, with or without undermining) is performed, use ONE of code 1597 or 1598, which is payable in full with the Mohs codes listed, In some cases the repair may be carried out by consultant Plastic Surgeon. If an In-patient stay is medically necessary for extensive repairs, this should be fully documented on the claim form. Each case will be assessed on an individual case basis.

15.08	Conditions of payment for code 1581, 1582, 1583, 1584, 1596, 1597 and 1598 • Lesions located in anatomic areas with high risk of recurrence of tumour. These areas would include involvement of the face, especially around nose, eyes, mouth and central third of face), external ear and tragus, temple, scalp, mucosal lesions and nail bed and periungual areas; or • Areas of important tissue preservation, including the face, ears, hands, feet, perianal and genitals; or • Recurrent or incompletely excised malignant lesions, regardless of anatomic regions; or • Previously irradiated skin areas in any anatomic region; or • For exceptionally large (>/= 2cm in diameter) or rapidly growing lesions in any anatomic region; or • Tumours with aggressive histological patterns: basal cell carcinoma (BCC) morpheaform (sclerosing), basoquamous (metatypical or keratinising), perineural or perivascular involvement, infiltrating tumours, multicentric tumours, contiguous tumours (i.e. BCC and SCC): squamous cell carcinomas (SCC) ranging from undifferentiated to poorly differentiated and SCCs that are adenoid (acantholytic), adenosquamous, desmoplastic, infiltrative, perineural, periadnexal or perivascular; or • Tumours will ill defined borders; or • SCC associated with high risk of metastasis, including those arising in the following; Bowens disease (SCC in-situ); discoid lupus erythematosus; chronic osteomyelitis; lichen sclerosis et atrophicus; thermal or radiation injury; chronic sinuses and ulcers; and adenoid type lesions • The consultant performing Mohs surgery - usually a consultant Dermatologist - must have a special interest in Mohs surgery as demonstrated by - having completed a recognised fellowship training in Mohs surgery of a duration of at least one year in an approved training centre - providing Irish Life Health with a letter from the training programme director certifying that the consultant has practised Mohs surgery on a multitude of skin cancer types and achieved an in-depth experience in reconstruction such that the consultant can practise Mohs unsupervised - providing Irish Life Health with a training log of completed Mohs surgery cases validated by the training programme director - on request
15.10	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.
15.11	This code may only be claimed when performed in a Irish Life Health approved facility. Consultant benefit applies to the prescription and supervision of the infusion. The consultants providing the infusion service must be registered with Irish Life Health 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
15.12	Maximum benefit of one payment per twelve months, for a period of three years
15.13	Clinical indications for code 1624 • prevention of skeletal related events in patients with advanced malignancies of involving bone; • tumour induced hypercalcemia
15.14	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.

15.15	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 1573, 1574, 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.
15.16	Clinical indications for code 1629; • pain control for patients with metastatic carcinoma; • tumour induced osteolysis with or without tumour induced hypercalcemia; • Paget's disease
15.17	Conditions of payment are as follows: • Exceptional blood loss anaemia • Osteomyelitis • Radiation damage • Skin grafts and compromised flaps • Thermo burns • Acute air or gas embolism • Acute Carbon monoxide poisoning and smoke inhalation • Acute traumatic peripheral ischemia (including crush injuries and suturing of severed limbs) when loss of function, limb or life is threatened and HBOT is used in combination with standard therapy • Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management • Compromised skin grafts and flaps • Decompression illness • Exceptional blood loss anaemia only when there is overwhelming blood loss and transfusion is impossible because there is no suitable blood available • Radiation necrosis (brain radio necrosis, myoradionecrosis, osteoradionecrosis and other soft tissue radiation necrosis) • Thermal burns, acute (second and third degree)

15.18	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.
15.20	One or more of the following indications must be met for benefit: • A systemic reaction involving more than one system has occurred already. • Clinical history indicates that airway, breathing or blood pressure control has been affected as a result of probably adverse activity in a manner likely to have caused concern to the clinician • The challenge involves agents (either food or drugs) likely to induce particularly severe reactions. (e.g. peanuts, NSAID) • Laboratory evidence of sensitisation is present at a disproportionate level • Time kinetics of reaction sought and need for observation dictates that OPD challenge will not resolve a serious concern • Other circumstances deemed by the attending consultant to require an inpatient challenge, in a situation where Outpatient challenge would usually be undertaken, such circumstance to be specified on a case by case basis. Additional information required to establish medical necessity to be provided on the claim form for consideration by the Medical director of Irish Life Health
15.21	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 challenge following investigations carried out under the procedure code 5985
15.22	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.
15.24	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
15.25	Payable once per day of attendance

15.26	Benefit payable to a consultant medical oncologist or haematologist only. The service includes examination and assessment of the patient, patient and family counselling (if required), evaluation of all pre-treatment diagnostic tests, prescription and supervision of chemotherapy, and management of any adverse events that may arise. Where it is medically necessary for a patient to be admitted to a hospitals an inpatient and undergoes in patient evaluation, cytotoxic planning and delivery, only the inpatient attendance fee is payable.
15.27	Not claimable with codes 1619, 1624, 1629
15.28	Where these procedures are done in an Outpatient setting there is an enhanced surgeon fee. See Minor Procedure list.

31 Neurosurgery

Neurosurgery

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5290	Clipping aneurysm, anterior circulation (open procedure)		
5295	Craniectomy or craniotomy for cerebellar haematoma		
5320	Craniectomy for excision of brain tumour, supratentorial		
5325	Penetrating brain injury with removal foreign body		
5365	Craniectomy for meningioma, supratentorial		
5370	CSF leak repair via craniectomy or nasal endoscopy	I.P.	
5376	Craniotomy for excision epileptic focus		
5377	Craniotomy for lobectomy (epilepsy) with electrocorticography during surgery (includes removal of		
5378	Craniotomy with elevation of bone flap (for intractable epileptic seizures); for lobectomy, temporal, temporal lobe, without electrocorticiography during surgery.		
5379	Craniotomy with elevation of bone flap (to treat intractable mesial temporal lobe epilepsy); for selective amygdalohippocampectomy		
5400	Hemispherectomy		
5410	Craniectomy or craniotomy for intracerebral haematoma		
5420	Craniectomy or craniotomy for abscess		
5470	Craniotomy for removal of pituitary tumour or to resect a portion of gland		
5484	Stereotactic computer assisted volumetric intracranial procedure		3.01
5490	Burr hole for excavation and/or drainage of subdural haematoma		
5520	Shunt insertion		
5525	Shunt revision		
5645	Burr hole(s) for brain biopsy/abscess tapping	Diagnostic	
5650	Burr hole for ventricular puncture or intensive care monitoring (I.P.)	I.P.	
5665	Elevation depressed skull fracture		
5691	Consultant plastic surgeon, cranio facialplasty, including the correction of craniosynostoses and facial synostoses		
5692	Consultant neurosurgeon, neurosurgical involvement with cranio facialplasty		
5706	Twist drill, burr hole, craniotomy or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g. Thalamus, globus pallidus, subthalamic, nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording		
5707	Twist drill, burr hole, craniotomy or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g. Thalamus, globus pallidus, subthalamic, nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording 5708 Revision or removal of intracranial neurostimular electrodes		
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		3.02
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		3.02
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)		3.03

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5744	Burr hole(s) for brain biopsy/abscess tapping/implanting ventricular catheter, reservoir, EEG electrode(s) or pressure recording device		
5747	Craniectomy or craniotomy, exploratory, supratentorial (I.P.)	I.P.	
5748	Craniectomy or craniotomy, exploratory, infratentorial (I.P.)	I.P.	
5749	Craniectomy or craniotomy for extra/subdural haematoma		
5752	Craniectomy for nerve section/decompression		
5753	Craniectomy for bone tumour, supratentorial		
5754	Craniectomy for excision of brain tumour, infratentorial		
5757	Craniectomy for meningioma, infratentorial		
5758	Craniectomy for CP angle tumour (includes acoustic neuroma)		
5759	Craniectomy for midline skull base tumour		
5764	Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring		
5766	Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue		
5767	Craniotomy for transection of corpus callosum		
5768	Craniectomy for excision/fenestration cyst		
5769	Craniotomy for excision of craniopharyngioma (complete removal)		
5772	Single surgeon transnasal or transseptal approach to remove a pituitary tumour or resect a portion of gland	I.P.	
5773	Repair of encephalocoele, skull vault, including cranioplasty		
5774	Craniectomy for repair of skull base, encephalocoele		
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		
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		
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		
5779	Arteriovenous malformation, simple (<Spetzler 3)		
5781	Arteriovenous malformation, complex (>Spetzler 3)		
5782	Dural arteriovenous malformation		
5783	Clipping aneurysm, posterior circulation (open procedure)		
5784	Anastomosis, arterial, extracranial-intracranial (e.g., middle cerebral/cortical) arteries		
5786	Stereotactic lesioning (functional)		
5787	Stereotactic biopsy (CAT or MRI targeted)		
5788	Cranioplasty for skull defect (I.P.)	I.P.	
5789	Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion (I.P.)	I.P.	
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.	
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.	
5796	Shunt removal		
5797	Endoscopic third ventriculostomy or cyst fenestration		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
5981	Neuroplasty and/or transposition ulnar nerve	Daycare	
5751	Craniectomy for foramen magnum decompression (A-C; syringo)		

Nerves

5586	Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve (e.g. for blepharospasm, hemifacial spasm)		
5590	Intracranial sensory root division (trigeminal)		
5600	Peripheral nerve repairs		
5605	Peripheral nerve tumour, excision of	Daycare	
5606	Implantation of neurostimulator electrodes, Vagus nerve		
5610	Sensory nerve, neurectomy		
5622	E.C.T. (each session)	Daycare	

Other Procedures

5690	Osteoma calvarium, excision of	Daycare	
5693	Skull bone grafting to facial skeleton		
5695	Platybasia, repair of		
5725	Anomalies of cord vascular, operation for		
5741	Intraoperative neurophysiology testing by a Consultant Neurophysiologist to monitor motor evoked potentials/ sensory evoked potentials of the spinal cord during spinal surgery.		
5743	Botulinum toxin injection for treatment of cervical dystonia Side Room		
5756	Intrathecal cytotoxic chemotherapy infusion Side Room		
5761	Cervical sympathectomy, unilateral		
5762	Cervical sympathectomy, bilateral		
5763	Exploration of the brachial plexus with removal of tumours		
5765	Lumbar sympathectomy, unilateral		
5770	Lumbar sympathectomy, bilateral		
5771	Nerve root tumours, transthoracic or abdominal removal		
5880	EMG - in an approved Irish Life Health recognised Laboratory (IP) Diagnostic, Side Room Service,	I.P.	
5881	Electromyography study, rectal mucosal sensitivity testing (IP)	Diagnostic, Side Room, I.P.	
5905	Video telemetric EEG recordings including full clinical evaluation and placement of sphenoidal electrodes.		3.04
5906	Video telemetric EEG recordings including full clinical evaluation following placement of sub dural electrodes.		3.04
5292	Detachable balloon occlusion of carotico cavernous aneurysms and fistulae		

NEUROSURGERY - PAYMENT RULES

3.01	Payable in full with main benefit
3.02	Code 5711 is not claimable with Code 5712
3.03	Benefit is payable in full when performed with code 5711 or 5712
3.04	For procedure codes 5905 and 5906 the benefit incorporates all in-patient attendance

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Ophthalmic Operations

Anterior Segment

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2523	Removal of foreign body from anterior chamber, non-magnetic		
2524	Removal of implanted material from anterior chamber		
2525	Paracentesis of anterior chamber of eye with or without diagnostic aspiration of aqueous (I.P.) I.P., Daycare		
2528	Intravitreal injection of a pharmacological agent with or without paracentesis. Only for use where the intravitreal agents are not listed separately in this schedule.	Side Room, I.P.	4.01
2529	Intravitreal injection of Macugen for the treatment of neovascular (wet) age-related macular degeneration (AMD) (I.P.)	Side Room, I.P.	4.02, 4.12
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, I.P.	
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, I.P.	
2580	Paracentesis of anterior chamber of eye for hyphaema with or without irrigation and/or air injection		
2586	Reform anterior chamber secondary to trabeculectomy or post cataract surgery	Daycare	
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	Side Room, I.P.	4.02
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	Side Room, I.P.	4.02
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	Side Room, I.P.	4.02
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	Side Room, I.P.	4.02
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	Side Room, I.P.	4.02
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	Side Room, I.P.	4.02
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	Side Room, I.P.	4.02
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	Side Room, I.P.	4.02
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	Side Room, I.P.	4.02
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	Side Room, I.P.	4.02
2561	Left eye, intravitreal injection of Eylea (Aflibercept) for the treatment of neovascular (wet) agerelated macular degeneration (AMD) (Benefit is payable in a hospital setting only)	Side Room, I.P.	4.02
2562	Right eye, intravitreal injection of Eylea (Aflibercept) for the treatment of neovascular (wet) agerelated macular degeneration (AMD) (Benefit is payable in a hospital setting only)	Side Room, I.P.	4.02
2567	Left eye, intravitreal injection of Avastin for the treatment of visual impairment due to macular oedema secondary to retinal vein occlusion (RVO).	Side Room, I.P.	4.02
2568	Right eye, intravitreal injection of Avastin for the treatment of visual impairment due to macular oedema secondary to retinal vein occlusion (RVO).	Side Room, I.P.	4.02

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2571	Left eye, intravitreal injection of Eylea (aflibercept) for the treatment of visual impairment due to macular oedema secondary to central retinal vein occlusion (CRVO)	Side Room, I.P.	4.02
2572	Right eye, intravitreal injection of Eylea (aflibercept) for the treatment of visual impairment due to macular oedema secondary to central retinal vein occlusion (CRVO)	Side Room, I.P.	4.02

Conjunctiva

2490	Conjunctival flap		
2493	Conjunctivectomy		
2495	Conjunctival graft		
2496	Cryotherapy, unilateral	Daycare	
2497	Cryotherapy, bilateral	Daycare	
2498	Conjunctival tumour with or without graft	Daycare	
2500	Conjunctival cyst/Granuloma, one or more excision of	Side Room	
2521	Symblepharon division		
2522	Removal of foreign body from anterior chamber, magnetic	Daycare	
2526	Symblephora, division of (includes conjunctival graft)		
2527	Conjunctival biopsy	Side Room	
2505	Foreign body, removal of, from conjunctiva	Service, Side Room/ Outpatient	4.28
2520	Conjunctival wounds, repair	Service, Side Room/ Outpatient	4.28

Cornea and Sclera

2510	Pterygium removal	Daycare	
2511	Pterygium removal and conjunctival graft	Daycare	
2530	Corneal grafting of un-cut graft, penetrating/lamellar		
2531	Removal of sutures (late Stage) post corneal grafting; corneal/sclera	Side Room, MAC	
2535	Corneal surface removed and EDTA application	Side Room, MAC	
2540	Corneal tattooing		
2546	Corneal scraping	Daycare	
2547	Corneal biopsy		
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	
2555	Corneal or scleral tumour, excision		
2556	Perforating injury cornea and/or sclera not involving uveal tissue		
2565	Perforating injury cornea and/or sclera with reposition or resection of uveal tissue		
2566	Repair of scleral staphyloma with or without graft		
2575	Foreign body, removal of, from cornea	Service, Side Room	
2577	Keratotomy, corneal relaxing incision or wedge resection for correction of surgically induced astigmatism that resulted from previous surgery (not for the correction of refractive errors to correct short sightedness, long sightedness or astigmatism) (I.P.)	I.P., Daycare	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2579	Excimer laser therapy for the correction of corneal diseases e.g.. corneal dystrophy, epithelial membrane dystrophy, irregular corneal surfaces due to Salzmann's nodular degeneration or keratoconus nodules, or post traumatic corneal scars and opacities or recurrent corneal erosions. Not for the correction of refractive errors (LASIK), the treatment of infectious keratitis or for the correction of post surgical corneal scars that arise as a result of surgery for which Irish Life Health benefit is not payable	Side Room	4.04
2549	Corneal grafting of pre-cut graft, penetrating/lamellar (not INTACS)		
2800	INTACS for members suffering from Keratoconous (I.P)	I.P., Side Room, Pre-Auth	4.06, 4.13
2801	Corneal Cross Linking (I.P.)	I.P., Side Room, Pre-Auth	4.07
2761	Lacrimal sac, syringing and probing, unilateral or bilateral	I.P.,Side Room	
2775	Lacrimal sac, syringing	I.P.,Side Room	

Eyelids

2591	Botulinum injection for blepharospasm or to induce ptosis	I.P.,Side Room	
2592	Repair of ectropion; suture or thermo cauterization	Side Room	
2595	Repair of ectropion; excision of tarsal wedge/extensive (e.g. tarsal strip operations)	Daycare	
2596	Blepharophimosis, for pathology (not cosmetic)	Daycare	
2600	Repair of entropion; excision tarsal wedge/extensive (e.g. tarsal strip or capsulopalpebral fascia repairs operation)	Daycare	
2601	Repair of entropion; suture or thermo cauterization	Side Room	
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	
2610	Injury to eyelid, repair (superficial)	Side Room, MAC	
2611	Opening of tarsorrhaphy (I.P.)	I.P., Side Room, MAC	
2615	Injury to eyelid, repair (deep)		
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	
2622	Excision of chalazions, papilloma's, dermoids or other cysts or lesions, one or both eyelids, involving skin, lid margin, tarsus and/or palpebral conjunctiva (I.P.)	I.P., Side Room, Service, MAC	
2626	Canthotomy (I.P.)	I.P., Side Room	
2630	Tarsorrhaphy Daycare		

Globe

2635	Evisceration of eye		
2640	Excision of eye plus implant		
2645	Removal of intraocular foreign body		
2660	Removal of eye		

Iris, Ciliary Body and Choroid

2680	Division of anterior synechiae (I.P.)	I.P., Daycare	
2685	Cyclodialysis		
2696	Ciliary body destruction; Cyclocryotherapy or Diathermy	Daycare	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2700	Goniotomy		
2710	Iridectomy		
2711	Pupil reconstruction post trauma, post surgery		
2725	Iris tumour, removal		
2726	Iris biopsy (I.P.)	I.P.	
2740	Trabeculectomy/Drainage procedure	1 Night Only	
2741	Laser trabeculoplasty, one or more treatments	Side Room	
2742	Trabeculectomy and tubes, etc.	Daycare	
2845	Local resection of ciliary body or choroidal tumour		

Lacrimal Apparatus

2750	Canaliculus repair with or without tube	Daycare	
2755	Dacryocystorhinostomy with or without tubes	Daycare, I.P.	
2756	Removal of D.C.R. tube	Side Room	
2760	Lacrimal abscess, (dacrocystitis) incision	Side Room	
2764	Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent (I.P.)	I.P., Daycare	
2766	Punctal closure with cautery or controller	Side Room	
2768	3 Snip operation of lacrimal punctum	Side Room	
2769	Correction of everted punctum : cautery only	Side Room	
2770	Lacrimal sac excision (dacryocystectomy)		
2771	Lacrimal gland tumour excision		
2772	Conjunctivo - dacryocystorhinostomy with Lester Jones tube	Daycare	

Laser / Light Coagulation

2644	Argon or Diode laser or Xenon Arc, for treatment of retinal or choroidal disease, glaucoma, one or more treatments	Side Room, I.P.	
2647	YAG laser, for pupil formation, iridectomy, membranectomy, ciliary body treatment, glaucoma, one or more treatments.	Side Room, I.P.	
2648	YAG laser capsulotomy, post cataract surgery, one or more treatments (details of previous cataract surgery must be provided on the claim form)	Side Room	4.04
2806	Argon laser therapy for pan - retinal photocoagulation of diabetic retinopathy or central retinal vein occlusion (per course of therapy)	Side Room	
2807	Photodynamic therapy for exudative macular degeneration (one eye) - all inclusive benefit including pre-therapy assessment and counselling, infusion of 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)	Side Room	4.05
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)	Side Room	4.05

Lens

2779	Repositioning of intraocular lens prosthesis requiring an incision (I.P.) Daycare, I.P. 4.09		
2780	Intraocular lens insertion not associated with concurrent cataract removal secondary implant, for exchange lens associated with previous cataract surgery only (I.P.)	Daycare, I.P.,Pre-Auth for under 60's	4.09

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2785	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (I.P.)	I.P.	
2786	Revision or repair of operative wound of anterior segment of the eye, any type, early or late, major or minor procedure	I.P.	
2795	Lens extraction Daycare		4.09
2802	Cataract extraction plus insertion of artificial lens (includes phacoemulsification, etc.)	Daycare, Pre-Auth for under 60's	4.09
2803	For cataract extraction operations, all forms, where only monitored anaesthesia care is given, the anaesthetic benefit payable is shown opposite		
2804	Cataract extraction plus insertion of artificial lens (includes phacoemulsification, etc.) Children up to 16 years of age.		4.09
2781	Artisan lens implantation for aphakia	Daycare, I.P., Pre-Auth	4.1

Muscles

2870	Routine squint operation, horizontal, vertical or oblique	Daycare	
2871	Transposition surgery, Jansens, Hummelsheim, Knapp procedure		
2872	Post operative adjustment(s) of suture(s) (payable once only following strabismus surgery)	Side Room, I.P.	
2873	Botulinum toxin injection to extraocular muscles	Service, Side Room	
2874	Muscle biopsy (I.P.)	I.P.	

Orbit

2890	Orbit, exenteration of		
2895	Orbit, exploration of, including biopsy	Daycare	
2900	Orbit, removal of foreign body from		
2905	Orbit, removal of tumour from (Kronlein's operation)		
2910	Orbit, repair of fracture of	Daycare	
2911	Orbitotomy		
2912	Transnasal wiring		
2915	Orbit, repair of fracture of, with plastic implant		

Posterior Segment

2506	Removal of silicone oil not associated with retinal repair at same operative session	Daycare	
2665	Prophylaxis of retinal detachment (e.g. retinal break, lattice degeneration), one or more sessions cryotherapy, diathermy, or photocoagulation/laser	Side Room	4.03
2675	Repair of retinal detachment, retinopexy with scleral buckling, scleral resection or scleral implant, etc. (For diathermy, cryotherapy or photocoagulation use code 2665)	4.03	
2676	Vitrectomy - including Prophylaxis of retinal detachment (e.g. retinal break, lattice degeneration), one or more sessions cryotherapy, diathermy, or photocoagulation/laser	1 Night Only	4.03
2677	Complex repair of retinal detachment, retionopexy with scleral buckling, scleral resection or scleral implant, includes vitrectomy, claimable only when membrane dissection is also involved - including Prophylaxis of retinal detachment (e.g. retinal break, lattice degeneration), one or more sessions cryotherapy, diathermy, or photocoagulation/laser	I.P.	
2875	Retrobulbar, orbital floor, subconjunctival, subtenons and facial nerve injections (I.P.)	I.P., Side Room	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
2880	Examination of eye under general anaesthetic (I.P.)	I.P., Diagnostic, Daycare	
2926	Fluorescein angiography (I.P.)	I.P., Diagnostic, Side Room	
2927	Tensilon (Edrophonium) test	Side Room	
2678	Left eye, intravitreal injection of Jetrea (Ocriplasmin) in adults for the treatment of vitreomacular traction (VMT), including when associated with macular hole of a diameter less than or equal to 400 microns. Claimable once only per lifetime. (Benefit is payable in a hospital setting only)	Side Room	4.11
2679	Right eye, intravitreal injection of Jetrea (Ocriplasmin) in adults for the treatment of vitreomacular traction (VMT), including when associated with macular hole of a diameter less than or equal to 400 microns. Claimable once only per lifetime. (Benefit is payable in a hospital setting only)	Side Room	4.11

OPHTHALMIC OPERATIONS - PAYMENT RULES

4.01	Not for use where the intravitreal agents are listed separately in this Schedule. The intravitreal agent used must be stated on the claim form. If it is medically necessary for a Consultant Anaesthetist to provide any form of anaesthetic then an Anaesthetist report must be completed by the Consultant Anaesthetist and submitted with the claim form.
4.02	Benefit is payable for 9 injections per eye in any 12 month period, in excess of this pre authorisation is required
4.03	Codes 2665, 2675 and 2676 cannot be combined for benefit payment purposes
4.04	Details of previous cataract surgery must be provided on the claim form
4.05	Benefit is payable for codes 2807 and 2808 for: • The treatment of wet age related degeneration for individuals who have a confirmed diagnosis of – Predominantly classic lesions or – Pure occult lesions Benefit is not payable for minimally classic or mixed lesions • Best corrected visual acuity 6/60 or better
4.06	In an approved Irish Life Health facility. Only for members suffering from Keratoconous and has a clear central cornea
4.07	In an approved Irish Life Health facility, having submitted a full report on the members condition
4.09	Prosthesis benefit is payable up to the value of monofocal lens only. Benefit is not payable for elective refractive lens replacement surgery, However the Irish Life Health 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 Irish Life Health 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 Irish Life Health. Benefit is not payable for lens extraction for prevention or treatment of glaucoma. Benefit will be paid for one overnight stay in hospital when the surgery and procedure ground rules are met and in addition for patients with ASA 1 or III in the following exceptional circumstances: • patients with only one eye • co-existing eye disease e.g. glaucoma, uveitis • previous retinal surgery • eye injury causing corneal scarring • lens subluxation
4.10	Procedure must be secondary to: • Congenital cataract surgery where the best corrected vision using contact lens is 6/12 or there are medical contraindications to the wearing of contact lenses (details of such contraindications to be provided) or • Lens dislocation where the best corrected vision using contact lenses is 6/12 or worse or there are medical contraindications to the wearing of contact lenses (details of such contraindications to be provided) or • Cataract surgery where it is certified that a secondary implant is medically necessary because of a displaced lens or capsule rupture or • Cataract surgery following previous retinal detachment treated by vitrectomy.
4.11	For procedures 2678 and 2679 benefit is only payable where the intravitreal agent listed is used for the stated indication.
4.28	These procedures can be done in an Outpatient setting. See Minor Procedures list.
4.13	Only for members suffering from Keratoconous and has a clear central cornea

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Medical

Medical

CODE	DESCRIPTION	SPECIALIST
8400	Acute severe ventilatory failure (PaO2 less than 8 kPa) occurring as an acute event	In-Patient Attendance And Other Medical Services
8401	Acute pulmonary oedema	In-Patient Attendance And Other Medical Services
8405	Life-threatening broncho-pulmonary haemorrhage	In-Patient Attendance And Other Medical Services
8410	Congenital conditions of the new-born associated with acute continuous respiratory distress	In-Patient Attendance And Other Medical Services
8415	Hyaline membrane disease, ventilation and/or CPAP	In-Patient Attendance And Other Medical Services
8420	Pneumothorax or pneumomediastinum necessitating insertion of underwater seal	In-Patient Attendance And Other Medical Services
8425	Acute airway obstruction by foreign body	In-Patient Attendance And Other Medical Services
8430	Acute bronchiolitis in infants	In-Patient Attendance And Other Medical Services
8432	Severe/acute asthma in a child requiring supplemental oxygen therapy	In-Patient Attendance And 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 And Other Medical Services
8435	Acute myocardial infarction	In-Patient Attendance And Other Medical Services
8437	Life threatening rhythm disturbances	In-Patient Attendance And Other Medical Services
8440	Cardiogenic shock	In-Patient Attendance And Other Medical Services
8445	Acute rheumatic heart disease	In-Patient Attendance And Other Medical Services
8450	Congenital conditions of the new-born associated with cyanosis and heart failure	In-Patient Attendance And Other Medical Services
8455	Hypotensive shock	In-Patient Attendance And Other Medical Services
8460	Hypertensive crisis	In-Patient Attendance And Other Medical Services
8465	Cardiac arrest	In-Patient Attendance And Other Medical Services
8470	Acute bacterial endocarditis (myocarditis or pericarditis)	In-Patient Attendance And Other Medical Services
8475	Massive gastrointestinal haemorrhage	In-Patient Attendance And Other Medical Services
8480	Acute infantile diarrhoeal disease, causing dehydration and metabolic disturbance	In-Patient Attendance And Other Medical Services
8485	Acute liver failure	In-Patient Attendance And Other Medical Services
8490	Congenital condition of the new-born associated with acute continuous digestive disturbances	In-Patient Attendance And Other Medical Services
8495	Paediatric conditions requiring hyperalimentation	In-Patient Attendance And Other Medical Services

CODE	DESCRIPTION	SPECIALIST
8500	Paediatric necrotising enterocolitis	In-Patient Attendance And 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 And 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 And Other Medical Services
8506	Generalised tonic-clonic seizures with major convulsions occurring	In-Patient Attendance And Other Medical Services
8515	Reye's syndrome	In-Patient Attendance And Other Medical Services
8520	Acute renal failure	In-Patient Attendance And Other Medical Services
8525	Diabetic ketoacidosis	In-Patient Attendance And 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 And Other Medical Services
8535	Septicaemia/endotoxic shock	In-Patient Attendance And Other Medical Services
8540	Acute life endangering poisonings requiring high intensity intervention	In-Patient Attendance And Other Medical Services
8530	Primary blood dyscrasia or lymphoma with acute manifestations	In-Patient Attendance And Other Medical Services
8541	Total marrow failure, acute manifestations arising as a result of a disease process. Not claimable for the management of a patient with marrow suppression while on cytotoxic chemotherapy	In-Patient Attendance And Other Medical Services
8545	Major trauma, not involving surgery	In-Patient Attendance And Other Medical Services
8550	Other reasons, by report as notified and approved for benefit by Irish Life Health	In-Patient Attendance And 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 And Other Medical Services
8565	Hodgkin's disease	In-Patient Attendance And Other Medical Services
8570	Aggressive non-Hodgkin's lymphomas	In-Patient Attendance And Other Medical Services
8575	Testicular and other germ cell tumours	In-Patient Attendance And Other Medical Services
8580	Sarcomas of bone	In-Patient Attendance And Other Medical Services
8585	Ewing's sarcomas and other small blue round-cell tumours	In-Patient Attendance And Other Medical Services
8690	Palliative Care Consultation	Palliative Medicine Consultation

CODE	DESCRIPTION	SPECIALIST
8692	Consultant Geriatrician In-Patient Consultation	Geriatric Consultation
8697	Consultant Neurologist In-Patient Consultation	In-Patient Attendance And Other Medical Services
8694	Consultant Neonatologist or Paediatrician In-Patient Consultation	Neonatology Consultation
10072	An inpatient palliative medicine consultation	Palliative Medicine Consultation
11066	Inpatient consultation	
10068	A major inpatient psychiatric consultation	In-Patient Attendance And Other Medical Services
8696	Consultant Radiologist Inpatient consultation	
8700	24 Hour E.C.G.	In-Patient Attendance And Other Medical Services
8705	EEG	In-Patient Attendance And Other Medical Services
8706	24 hour in-patient ambulatory EEG; monitoring for localisation of cerebral seizure focus	In-Patient Attendance And Other Medical Services
8707	Inpatient EEG; monitoring for localisation of cerebral seizure focus with a minimum of 4 hour video recording	In-Patient Attendance And Other Medical Services
8710	Evoked potentials	In-Patient Attendance And Other Medical Services
8586	Anorexia Nervosa, severely symptomatic patients with body weight (75% or 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 And Other Medical Services
8693	Day Care Inpatient Management	In-Patient Attendance And Other Medical Services
10000	Medical Management For Specific Paediatric Medical Day Care Procedures/Investigations	In-Patient Attendance And Other Medical Services
10010	Emergency Overnight Medical Admission for Neonates or medical care	Neonatology
10011	Elective postoperative night Medical Admission for Neonates	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
10030	Neonatal Intensive Care - Inpatient Attendance Benefit 14 Day Stay	Neonatology
10031	Neonatal Intensive Care - Inpatient Attendance Benefit 15 Day Stay	Neonatology
10071	Inpatient Neonatology Intensive Care Attendance Per Day After Day 15 Of Stay	In-Patient Attendance And Other Medical Services
10032	Neonatal Intensive Care Inpatient Consultation	Neonatology

CODE	DESCRIPTION	SPECIALIST
10034	Anaesthesia - ICU Inpatient Medicine Benefit 1 day stay	In-Patient Attendance And Other Medical Services
10035	Anaesthesia - ICU Inpatient Medicine Benefit 2 day stay	In-Patient Attendance And Other Medical Services
10036	Anaesthesia - ICU Inpatient Medicine Benefit 3 day stay	In-Patient Attendance And Other Medical Services
10037	Anaesthesia - ICU Inpatient Medicine Benefit 4 day stay	In-Patient Attendance And Other Medical Services
10038	Anaesthesia - ICU Inpatient Medicine Benefit 5 day stay	In-Patient Attendance And Other Medical Services
10039	Anaesthesia - ICU Inpatient Medicine Benefit 6 day stay	In-Patient Attendance And Other Medical Services
10040	Anaesthesia - ICU Inpatient Medicine Benefit 7 day stay	In-Patient Attendance And Other Medical Services
10041	Anaesthesia - ICU Inpatient Medicine Benefit 8 day stay	In-Patient Attendance And Other Medical Services
10042	Anaesthesia - ICU Inpatient Medicine Benefit 9 day stay	In-Patient Attendance And Other Medical Services
10043	Anaesthesia - ICU Inpatient Medicine Benefit 10 day stay	In-Patient Attendance And Other Medical Services
10044	Anaesthesia - ICU Inpatient Medicine Benefit 11 day stay	In-Patient Attendance And Other Medical Services
10045	Anaesthesia - ICU Inpatient Medicine Benefit 12 day stay	In-Patient Attendance And Other Medical Services
10046	Anaesthesia - ICU Inpatient Medicine Benefit 13 day stay	In-Patient Attendance And Other Medical Services
10047	Anaesthesia - ICU Inpatient Medicine Benefit 14 day stay	In-Patient Attendance And Other Medical Services
10048	Anaesthesia - ICU Inpatient Medicine Benefit 15 day stay	In-Patient Attendance And Other Medical Services
10069	Anaesthesia - ICU Inpatient Medicine Benefit per day after day 15 of stay	In-Patient Attendance And Other Medical Services
10049	Inpatient Medical Service attendance 1 day stay	In-Patient Attendance And Other Medical Services
10050	Inpatient Medical Service attendance 2 day stay	In-Patient Attendance And Other Medical Services
10051	Inpatient Medical Service attendance 3 day stay	In-Patient Attendance And Other Medical Services
10052	Inpatient Medical Service attendance 4 day stay	In-Patient Attendance And Other Medical Services
10053	Inpatient Medical Service attendance 5 day stay	In-Patient Attendance And Other Medical Services
10054	Inpatient Medical Service attendance 6 day stay	In-Patient Attendance And Other Medical Services
10055	Inpatient Medical Service attendance 7 day stay	In-Patient Attendance And Other Medical Services
10056	Inpatient Medical Service attendance 8 day stay	In-Patient Attendance And Other Medical Services
10057	Inpatient Medical Service attendance 9 day stay	In-Patient Attendance And Other Medical Services

CODE	DESCRIPTION	SPECIALIST
10058	Inpatient Medical Service attendance 10 day stay	In-Patient Attendance And Other Medical Services
10059	Inpatient Medical Service attendance 11 day stay	In-Patient Attendance And Other Medical Services
10060	Inpatient Medical Service attendance 12 day stay	In-Patient Attendance And Other Medical Services
10061	Inpatient Medical Service attendance 13 day stay	In-Patient Attendance And Other Medical Services
10062	Inpatient Medical Service attendance 14 day stay	In-Patient Attendance And Other Medical Services
10063	Inpatient Medical Service attendance 15 day stay	In-Patient Attendance And Other Medical Services
10070	Inpatient Medical Service attendance per day after day 15 of stay	In-Patient Attendance And Other Medical Services
10064	Inpatient Major Medical Illnesses	In-Patient Attendance And Other Medical Services
10081	Paediatricintensive Care - Inpatient Attendance Benefit 1 Day Stay	Neonatology
10082	Paediatricintensive Care - Inpatient Attendance Benefit 2 Day Stay	Neonatology
10083	Paediatricintensive Care - Inpatient Attendance Benefit 3 Day Stay	Neonatology
10084	Paediatricintensive Care - Inpatient Attendance Benefit 4 Day Stay	Neonatology
10085	Paediatricintensive Care - Inpatient Attendance Benefit 5 Day Stay	Neonatology
10086	Paediatricintensive Care - Inpatient Attendance Benefit 6 Day Stay	Neonatology
10087	Paediatricintensive Care - Inpatient Attendance Benefit 7 Day Stay	Neonatology
10088	Paediatricintensive Care - Inpatient Attendance Benefit 8 Day Stay	Neonatology
10089	Paediatricintensive Care - Inpatient Attendance Benefit 9 Day Stay	Neonatology
10090	Paediatricintensive Care - Inpatient Attendance Benefit 10 Day Stay	Neonatology
10091	Paediatricintensive Care - Inpatient Attendance Benefit 11 Day Stay	Neonatology
10092	Paediatricintensive Care - Inpatient Attendance Benefit 12 Day Stay	Neonatology
10093	Paediatricintensive Care - Inpatient Attendance Benefit 13 Day Stay	Neonatology
10094	Paediatricintensive Care - Inpatient Attendance Benefit 14 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

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MRI

DESCRIPTION	WITHOUT CONTRAST	WITH CONTRAST
Head, includes orbits and MRA if performed		
for exclusion and/or further investigation and monitoring of;		
Tumour of the brain or meninges	62300001	62310001
Skull base or orbital tumour	62300011	62310011
Acoustic neuroma	62300021	62310021
Pituitary tumour - in the case of females with elevated prolactin levels, MRI benefit is only allowable following repeated testing and exclusion of the presence of macro prolactin and there continues to be significant hyperprolactinaemia	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
Screening of intracranial aneurysm in the following high risk individuals - positive family history, defined as 2 or more first degree relatives with subarachnoid haemorrhages	62300121	62310121
Screening of intracranial aneurysm in the following high risk individuals - patients with polycystic kidney disease	62300131	62310131
Head trauma	62300131	62310131
Epilepsy	62300141	62310141
Stroke	62300151	62310151
Post-operative follow-up after brain surgery	62300161	62310161
MRA for exclusion or further investigation of stroke	62300181	62310161
Vertebral dissection	62300191	62310191
MRA for exclusion or further investigation of intracranial aneurysm	62300201	62310201
MRA for exclusion or further investigation of intracranial arteriovenous malformation	62300211	62310211
MRA for exclusion or further investigation of venous sinus thrombosis	62300221	62310221

Note MRI of Head is not claimable with MRI for ophthalmic operations

Ophthalmic

for further investigation and monitoring of;

Suspected intra-orbital or visual pathway lesions	62300301	62310301
Dysthyroid eye disease	62300311	62310311
Diplopia	62300321	62310321

Note MRI of Head is not claimable with MRI for ophthalmic operations

Spine

Cervical or Thoracic or Lumbar radiculopathy, neck pain/mid/low back pain, spinal cord abnormality or spinal stenosis, for exclusion and/or further investigation and monitoring of :

Tumour of the CNS or meninges	62300401	62310401
Inflammation of the CNS or meninges	62300411	62310411

DESCRIPTION	WITHOUT CONTRAST	WITH CONTRAST
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
Absent or reduced sensation on clinical examination	62300471	62310471
Absent or reduced reflexes	62300481	62310481
Muscle wasting	62300491	62310491
Severe intractable arm pain where symptoms have been present for more than 6 weeks	62300501	62310501
Cervical/ thoracic or Lumbar radicular pain persisting for greater than 6 weeks when decompression surgery is being considered following referral by a consultant	62300511	62310511
Axial neck pain / thoracic back pain/axial lumbar spine pain, persisting for greater then 3 months following referral by a consultant	62300521	62310521
Reduced power on physical examination	62300531	62310531
Previous spinal surgery	62300541	62310541
Trauma	62300551	62310551
Spinal disease in pregnancy	62300561	62310561

Full details of all relevant symptoms and neurological signs that support the clinical indication for the MRI must be provided on the claim form. This MRI cannot be claimed with MRI of whole spine.

MRI of whole spine (cervical, thoracic and lumbar), for exclusion and/or further investigation and monitoring of :

Tumour of the CNS or meninges	62300571	62310571
Inflammation of the CNS or meninges	62300581	62310581
Demyelinating disease	62300591	62310591
Spinal cord compression (acute)	62300601	62310601
Congenital malformations of the spinal cord, cauda equina or meninges	62300611	62310611
Syrinx – congenital or acquired	62300621	62310621
Myelopathy	62300631	62310631
Absent or reduced sensation on clinical examination	62300641	62310641
Absent or reduced reflexes	62300651	62310651
Muscle wasting	62300661	62310661
Severe intractable arm pain where symptoms have been present for more than 6 weeks	62300671	62310671
Radicular pain persisting for greater than 6 weeks when decompression surgery is being considered following referral by a consultant	62300681	62310681
Axial spine pain, persisting for greater then 3 months following referral by a consultant	62300691	62310691
Reduced power on physical examination	62300701	62310701
Spinal disease in pregnancy	62300901	62310901
Previous spinal surgery	62300751	62310751
Trauma	62300761	62310761

DESCRIPTION	WITHOUT CONTRAST	WITH CONTRAST

Musculoskeletal System

for exclusion and/or further investigation and monitoring of:

Tumour arising in bone or other connective tissue	62301001	62311001
Infection arising in bone or other connective tissue	62301011	62311011
Osteonecrosis	62301021	62311021
Sacro-iliac joints in the following circumstances; (a) suspicion of the presence of ankylosing spondylitis and (b) patients have negative or inconclusive plan radiography films of the sacro-iliac joints and (c) patients are HLA B27 positive	62301031	62311031
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
Gaucher's disease	62301131	62311131

for investigation of;

Juvenile dermatomyositis by guiding biopsy	62301151	62311151

Hips

For exclusion, further investigation and monitoring of Derangement of one or both hips and supporting structures	62301161	62311161

Benefit is payable for scanning of derangement of one or both hips and supporting structures only when there are both symptoms and signs that have not responded to conservative therapy (i.e. analgesia and/or physiotherapy) and when hip x-ray is non-diagnostic for the aetiology of the underlying condition.

MRI of Knee(s)

For exclusion, further investigation and monitoring of Derangement of one Knee and supporting structures	62301171	62311171
For exclusion, further investigation and monitoring of Derangement of both Knees and supporting structures	62301181	62311181

Code for one knee cannot be claimed with code for both knees

Clinical indications:

- Acute pain secondary to trauma in the presence of an effusion without fracture on x-ray
- Suspected unstable knee with history of knee locking or positive McMurray test on examination
- Suspected stable meniscus tear following treatment with analgesia and physiotherapy and activity modification for at least 4 weeks in the presence of persistent joint effusion or history of locking
- Suspected cruciate ligament injury with a history of knee giving way and grade II-III instability (medial laxity of between 5 and 11 mm) on examination
- Suspected multi-ligamentous or lateral collateral ligament injury when there is grade II-III instability

DESCRIPTION	WITHOUT CONTRAST	WITH CONTRAST

- Suspected medial collateral ligament injury with grade II-III instability despite treatment with brace and activity modification for at least 6 weeks
- Other knee conditions of unknown aetiology when there are both symptoms and signs that suggest a significant underlying injury and when knee x-ray is non-diagnostic for the aetiology of the underlying condition

MRI of Other joints

ANKLE

One Ankle: benefit payable for scanning of derangement of ankle and supporting structures only	62307011	62317001
Both Ankles: benefit payable for scanning of derangement of ankles and supporting structures only	62307021	

Code for one ankle cannot be claimed with code for both ankles

FOOT/FEET

One Foot (excludes hind foot)	62307031	62317031
Both Feet (excludes hind feet)	62307041	62317041

Code for one ankle cannot be claimed with code for both ankles

Clinical Indications: Exclusion and/or investigation of

- suspected tarsal coalition	62307051	62317051
- soft tissue tumours in the feet	62307061	62317061
- posterior tibial nerve compression in the presence of persistent symptoms and signs and failure to respond to at least 6 weeks of appropriate therapy	62307071	62317071

SHOULDER(S)

One shoulder and supporting structures; benefit payable for scanning of derangement of shoulder and supporting structures only	62307081	62317081
Both shoulders and supporting structures; benefit payable for scanning of derangement of shoulders and supporting structures only	62307091	62317091

Code for one shoulder cannot be claimed with code for both shoulders

ELBOW(S)

One elbow and supporting structures; benefit payable for scanning of derangement of elbow and supporting structures only	62307101	62317101
Both elbows and supporting structures; benefit payable for scanning of derangement of elbows and supporting structures only	62307111	62317111

Code for one elbow cannot be claimed with code for both elbows

DESCRIPTION	WITHOUT CONTRAST	WITH CONTRAST
WRIST(S)		
One wrist and supporting structures; benefit payable for scanning of derangement of wrist and supporting structures only	62307121	62317121
Both wrists and supporting structures; benefit payable for scanning of derangement of wrists and supporting structures only	62307131	62317131

Code for one wrist cannot be claimed with code for both wrist

Cardiovascular System (including MRA if performed)

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

Clinical indications for MRI of abdomen

Characterisation of equivocal liver lesions identified in ultrasound or CT	62301311	62311311
Assessment of liver lesions in patients with known malignant disease for potential liver resection	62301321	62311321
Assessment of fistulae/abscesses/strictures in patients with established Crohn's disease following discussion with a multi-disciplinary team	62301401	62311401
Post surgical MRI following uterine artery embolisation for fibroids	62307141	62317141
Further investigation of adrenal masses identified on CT scanning	62307151	62317151
Further investigation of complex/ indeterminable / solid renal parenchymal masses	62307161	62317161
Placenta Accreta / Percreta	62307171	62317171
Staging of abdominal masses where CT is inconclusive	62301331	62311331
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 tumours not visible by CT, only if negative high resolution Triphassic CT scan of pancreas	62301391	62311391

for post operative evaluation of

Pre procedure planning for uterine artery embolisation of uterine fibroids - Adenomyosis	62301341	62311341
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

DESCRIPTION	WITHOUT CONTRAST	WITH CONTRAST

Magnetic Resonance Cholangiopancreatography (MRCP)

for further investigation of;

Pancreatic and biliary disease where conventional methodology has failed and ERCP is considered undesirable	62301601	62311601

MR enterography/enteroclysis

for further investigation of;

Exclusion of Crohn's disease in patients less than 18 years following review by a paediatrician	62307181	62317181
to assess disease activity in patients with Crohn's disease of the small bowel	62307191	62317191
To exclude Crohn's disease in patients with chronic abdominal pain, diarrhoea and weight loss when the referral for MRI is made by a consultant Gastroenterologist or surgeon with an interest in Gastrointestinal disease	62307201	62317201

Magnetic Resonance Angiography (MRA)

for exclusion or further investigation of;

Vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium	62301761	62311761
Renal artery stenosis post renal transplant	62301791	62311791
Renal artery stenosis in patients with refractory hypertension requiring multiple therapies, or in patients with documented renal insufficiency in whom renal vascular disease is being considered and in whom angioplasty and stenting is being considered	62301801	62311801
Obstruction of the superior vena cava, inferior vena cava or a major pelvic vein	62301771	62311771
Peripheral arteries to determine the presence and extent of peripheral arterial disease in lower extremities	62307211	62317211

Breast

Breast Cancer- where mammogram and/or ultrasound are negative for pathology but there continues to be a high index of clinical suspicion (e.g. in persons with inherited BRCA1 and BRCA2 mutations	62307001	62317001
For pre-operative evaluation of patients with invasive lobular carcinoma	62307221	62317221
For pre-operative evaluation of patients with multi-focal or multi-centric disease and age less than 40 years	62307231	62317231
To rule out intra-capsular implant rupture following assessment by a breast or plastic surgeon, where breast ultrasound is equivocal or non-diagnostic	62307241	62317241

Body

for further investigation of;

Staging of rectal cancer	62301361	62311361
Staging of prostate cancer	62307251	62317251
Staging of gynaecologic malignancies (endometrial, cervical and ovarian)	62301351	62311351
Malignant soft tissue tumours for diagnosis and staging	62302501	62312501
Congenital uterine or anorectal abnormality	62302521	62312521
Post operative recurrence of rectal cancer following CT and if tissue remains	62301371	62311371

DESCRIPTION	WITHOUT CONTRAST	WITH CONTRAST
Staging of bladder cancer	62301381	62311381
Detection of small pancreatic tumours not visible by CT, only if negative high resolution Triphassic CT scan of pancreas	62301391	62311391

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 6	2312621

Other

MRI for other exceptions as agreed by the Medical Director of Irish Life Health - Pre-Auth		
MRI Contract Enhancement - benefit shown is payable once only in full with the above codes when contract enhancement is required		

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Pathology

CODE	DESCRIPTION	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 day case Chemotherapy (codes 1608, 1609 and 1619), where code 8900 will apply	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"	Category 1 (one or more investigations per admission)

CATEGORY 3

8970	MSU + culture	Category 3 (per investigation)
9045	Stool: ova, cysts and parasites (microscopy)	Category 3 (per investigation)
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 additional necessary tests. Code 9100 is not claimable in relation to screening swabs for MRSA or other antimicrobial resistant organisms (see code 9101)	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. Code 9101 is not payable during a Side Room, Daycare or 1 Night Only admission. Definition of **"at risk patient"** for MRSA testing • Previously known as being MRSA positive • Transfers from a hospital or medical institution • High risk patients for cardiac surgery,implantation surgery • Deep Body cavity surgery • Members suffering from wounds or ulcers • Intensive Care Unit admission	Category 3 (per investigation)
9202	Antibiotic assay - maximum payable, four per claim	Category 3 (per investigation) - maximum of 4 per claim
9204	MIC - Minimum Inhibitory Concentration	Category 3 (per investigation)
9207	Toxin levels (e.g. clostridium difficile/ botulinum). Exact toxin being investigated must be specified Category 3 (per investigation) 9223 HIV, STD or Hepatitis screen	Category 3 (per investigation)
9385	Interpretive review of viral, bacterial or fungal serology or viral culture by Consultant Microbiologist or Clinical Pathologist	Category 3 (per investigation)
9059	Catecholamine's and porphyrins - once per claim only	Category 3 (per investigation)
9060	Cholinesterase/pseudo cholinesterase - once per claim only	Category 3 (per claim
9061	Acylcarnitine Carnites - Total and Free	Category 3 (per investigation)
9030	Sweat investigation	Category 3 (per investigation)
9050	Immunofluorescence - single antibody e.g. ANF (not claimable with code 9392 or if this leads to typing in Categories 4 or 5)	Category 3 (per investigation)

CATEGORY 4

9160	Electrophoresis and chromatographic procedures (serum, lipoprotein, urine)	Category 4 (per investigation)
9175	CSF including oligoclonal bands	Category 4 (per investigation)
9181	Trace metals (blood, urine and/or Dialysate)	Category 4 (once per claim)
9180	Myeloma Screen including electrophoresis	Category 4 (per investigation)
9182	Vitamins A, D or E	Category 4 (per investigation)
8940	Urinary haemosiderin	Category 4 (per investigation)
9226	Thrombophilia screen - this consists of three or more of the following items: Antithrombin 3, Protein C, Protein S, APCR, Factor V Leiden mutation, prothrombin mutation, lupus anticoagulant, anti-cardiolipin antibodies, fibrinogen	Category 4 (per investigation)

CODE	DESCRIPTION	PATHOLOGY CATEGORY
9205	Antibody identification (transfusion) (one or more antibodies). This can be claimed when: (a) an antibody has been identified as part of the group and uncomplicated cross match incorporated into code 8900, and/or (b) there is a high level of clinical suspicion that an antibody of rare clinical significance (which would not be detected as part of the standard antibody screening performed as part of the group and uncomplicated cross match) is present. A full report must accompany any claim for 9205 and it must be proven that this test was medically necessary, otherwise the charge will be incorporated into 8900	Category 4 (per investigation)
9210	Haemoglobin electrophoresis	Category 4 (per investigation)
9507	Flow cytometry for CD4, CD8 and CD34 counts	Category 4 (per investigation)
9280	Gel electrophoresis	Category 4 (per investigation)
9694	Gene rearrangement studies	Category 4 (per investigation)

CATEGORY 5

Diagnostic Related Groups: These are claimable one per claim where a substantial clinical input has been received from Chemical Pathologist, Consultant Biochemist or Clinical Pathologist. For codes 9301, 9302, 9303, 9306 and 9312,9307 and 9309 these are claimable only for test results outside the clinically significant normal or expected range in view of the condition of the patient, and when the service requires the medical judgement of the pathologist, where the service results in a written report outside of the usual laboratory report (this benefit does not apply to brief comments recorded on the cumulative electronic eGFR report).

9301	Diabetic ketoacidosis /hyperosmolar non-ketotic coma	Category 5 (a) once per claim
9302	Acute Renal failure	Category 5 (a) once per claim
9303	Acute hepatic failure	Category 5 (a) once per claim
9306	Porphyria investigation	Category 5 (a) once per claim
9312	Hypoglycaemia - not secondary to any previously diagnosed condition (includes hypoglycaemia associated with insulin overdose) Investigation must include some of all of the following: • Insulin and C-Peptide • ketones • Beta-hydro butyrate and acetoacetate • Non-esterified fatty acids • Lactate and Pyruvate • Cortisol and growth hormone	Category 5 (a) once per claim
9161	Gas Chromatographic/Mass Spectrometer for organic acid(s), assay. Claimable when results reviewed, interpreted and reported by a chemical pathologist, consultant biochemist or clinical pathologist.	Category 5 (a) (per investigation)
9307	Full endocrinological investigation of infertility	Category 5 (a) once per claim
9309	Full investigations for inborn errors of metabolism in paediatric patients. (not including examinations from the National Newborn Screening Programme for Inherited Metabolic and Genetic Disorders)	Category 5 (a) once per claim
9392	Immunofluorescence - autoantibody screen and/or DNA Abs and/or subtyping (not claimable with 9050)	Category 5 (a) once per claim
9304	Dynamic endocrine function tests (Insulin Stress Test, Synacthen test, Dexamethasone suppression test, water deprivation test)	Category 5 (b) once per claim
9360	Surgical pathology, gross and microscopic examination, requiring examination of between 1 and 2 tissue blocks from specimen(s) retrieved during a single operation.	Category 5(b) (per investigation)
Note that when two or more tissue sources from separate sites require examination they should all be assigned one code only reflective of the total number of blocks it is necessary to examine. The separate sites must be identified on the claim form. Benefits for examination of a lesions or lesions are payable based on the total number of blocks it is necessary to examine and only one of codes 9360, 9530 or 9650 is payable.		

CODE	DESCRIPTION	PATHOLOGY CATEGORY
9381	Interpretive review of culture of CSF, blood by a Consultant Microbiologist or a Clinical Pathologist	Category 5(b) (per investigation)
9391	Antisperm antibodies	Category 5(b) (per investigation)
9270	Paraprotein typing	Category 5(b) (per investigation)
9605	Immune complex assays, not otherwise listed in Category 1	Category 5(b) (per investigation)
9393	Polymerase chain reaction	Category 5(b) (per investigation)

CATEGORY 6

9508	Peripheral blood stem harvesting examination	Category 6 (per investigation)
9501	Marrow aspirate (not immunocyto- see Category 8)	Category 6 (per investigation)
9502	Marrow trephine (see Cat 7 if trephine and aspirate done together)	Category 6 (per investigation)
9530	Surgical pathology, gross and microscopic examination, requiring examination of between 3 and 5 tissue blocks from specimen(s) retrieved during a single operation.	Category 6 (per investigation)
Note that when two or more tissue sources from separate sites require examination they should all be assigned one code only reflective of the total number of blocks it is necessary to examine. The separate sites must be identified on the claim form. Benefits for examination of a lesions or lesions are payable based on the total number of blocks it is necessary to examine and only one of codes 9360, 9530 or 9650 is payable.		
9531	Cell Block and smear examination from Fine Needle Aspiration biopsy	Category 6 (per investigation)
9539	Upper G.I. Series	Category 6 (per investigation)
9540	Colonoscopic series	Category 6 (per investigation)
9541	Prostate series	Category 6 (per investigation)
9550	Clinical (i.e. non screening) cytology (not including smear + section, see Cat 7)	Category 6 (per investigation)
9535	Lymph node	Category 6 (per investigation)
9545	Parathyroid gland	Category 6 (per investigation)
9503	HLA typing	Category 6 (per investigation)
9504	Immunofluorescence - microbial antibodies	Category 6 (per investigation)
9506	Electron microscopy	Category 6 (per investigation)

CATEGORY 7

9601	Liver, renal biopsies including special stains	Category 7 (per investigation)
9650	Surgical pathology, gross and microscopic examination, requiring examination of more than 5 tissue blocks from specimen(s) retrieved during a single operation.	Category 7 (per investigation)
Note that when two or more tissue sources from separate sites require examination they should all be assigned one code only reflective of the total number of blocks it is necessary to examine. The separate sites must be identified on the claim form. Benefits for examination of a lesions or lesions are payable based on the total number of blocks it is necessary to examine and only one of codes 9360, 9530 or 9650 is payable.		
9603	Marrow aspirate and trephine done together (i.e. by same Pathologist)	Category 7 (per investigation)
9604	Platelet Aggregation Studies	Category 7 (per investigation)
9606	Multimer analysis for Von Willebrand disease	Category 7 (per investigation)
9670	Frozen section immunofluorescence - direct or indirect	Category 7 (per investigation)

CATEGORY 8

9505	Immunocytochemistry	Category 8
9691	Immunohistochemistry (include fluorescence in-situ hybridisation)	Category 8 (only once per claim)

CODE	DESCRIPTION	PATHOLOGY CATEGORY
9693	Frozen section for rapid intraoperative diagnosis	Category 8 (only once per claim)
9695	Tumour aneuploidy by flow cytometry	Category 8 (only once per claim)
9696	Gene re-arrangement studies for the diagnosis of leukaemia or lymphoma (includes molecular isolation or extraction; enzymatic separation and nuclei acid probes)	Category 8 (only once per claim)

CATEGORY 9

9700	All tests associated with Obstetrics, including normal delivery, caesarean section and miscarriage	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)	

Note: for a better understanding of what the Pathology Categories mean, please refer to the handbook and rules.

Definition of "at risk patient" for MRSA testing:

- Previously known as being MRSA positive
- Transfers from a hospital or medical institution
- High risk patients for cardiac surgery, implantation surgery
- Deep body cavity surgery
- Members suffering from wounds or ulcers
- Intensive Care Unit admission

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Codes 8899/8900

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 1619), 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 cross-match
	Coagulation Factor Assays
	Cold Agglutinins
	Reticulocyte count
	FBC
	FBC & manual film +- eosinophil count
	Ferritin
	Fibrinogen
	HbH
	Direct/ Indirect Coombs's test
	Iron profile
	Monospot
	RBC auto haemolysis
	RBC osmotic fragility
	Platelet Agg.
	Serum Folate
	Red Cell Folate

Biochemistry	All nuclear medicine in-vitro investigations (except for those listed in Category 5)
	Biochemical profiles: • Renal - 1 or more • Hepatic - 1 or more • Cardiac - 1 or more • Thyroid - 1 or more • Bone (not PTH) - 1 or more • Lipids - 1 or more
	Biochemistry of hypertension
	Drug levels assays (except those under code 9202; including RIA)
	OGTT
	HbAIC
	High Performance Liquid Chromatography (HPLC)
	Single analytes
	Tumour markers

Immunology	á-1-Antitrypsin
	Allergens
	C3
	C4
	Caeruloplasmin
	CRP
	Cryoglobulins
	Allergen specific IgE
	Immunoglobulins
	Properdin Factor B (PFB)
	Rheumatoid Screen
	Anti-Streptolysin O
	Thyroid Antibodies
	Transferrin

Endocrinology	Hormone Levels (except those in category 5)
	Pregnancy test (serum)

Microbiology	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 Irish Life Health)
	Stool for Occult Blood
	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
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Interventional Radiology

Breast Procedures:

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1196	Stereotactic localisation core needle biopsy of breast	Side Room, Diagnostic, I.P.	
1197	Preoperative placement of needle localisation wire, breast, one or more lesions		22.01
1199	Placement of radiotherapy afterloading catheter(s) into the breast for interstitial radioelement (brachytherapy) application at the same time or subsequent to breast surgery, includes imaging guidance.		22.02
66744	Completed radiological examination and evaluation including imaging (mammography and/or ultrasound), and immediate image-guided percutaneous core needle biopsy; where performed on same day by a Consultant Radiologist (I.P.)	Side Room, Service, I.P.	
6743	Image-guided percutaneous core needle biopsy, including Consultant Radiologist interpretation and report (ultrasound or stereotactic localisation) (I.P.)	Side Room, I.P., MAC	
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.)	Side Room, I.P., MAC	

CT Procedures:

6111	CAT scanning for biopsy or drainage	Side Room, MAC	
6124	Ablation therapy for reduction or eradication of one or more pulmonary tumour(s) under CT guidance, including pleura or chest wall when involved by tumour extension, percutaneous radiofrequency (benefit for CT guidance included)	I.P.	

Angiogram Procedures:

6675	Angiogram (direct puncture, single vessel study, brachial, femoral) includes introduction of needles or catheter injection of contrast media and necessary pre and post injection care specifically related to the injection procedure	Daycare	
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 related to the injection procedure	Daycare	
6681	Single selective carotid angiography and/or vertebral study	Daycare	
6682	Bilateral carotid angiography study	Daycare	
6683	Bilateral carotid angiography and vertebral study	Daycare	

Genito-urinary procedures:

6676	Placement of fiducial markers for radiation therapy guidance of prostate (via needle, any approach), single or multiple includes ultrasound guidance	Side Room, MAC	
66684	Uterine artery embolisation for fibroids including angiography and fluoroscopy	I.P. 22.03	

Special Procedures:

6686	Biopsy of focal lesion in the liver, kidney, pancreas or spleen including embolisation (e.g. Gelfoam), if performed	Side Room, MAC	
6687	Biopsy of focal lesion, under CT guidance, in the liver, kidney, pancreas or spleen including embolisation (e.g. gelfoam), if performed Side Room, MAC		
6688	Radiofrequency ablation of liver tumour(s) including embolisation (e.g. gelfoam), if performed	Side Room	
6691	Radiofrequency ablation of renal tumour(s) including embolisation (e.g. gelfoam), if performed	Side Room	
6692	Biopsy of lymph nodes, deep, under CT guidance	Side Room, MAC	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
6706	Hepatic needle puncture/catheterisation for biliary procedures	Side Room	
6721	Spinal arteriogram	Side Room	
6741	Transcatheter permanent occlusion or embolisation, percutaneous, any method non-central nervous system, head or neck (extracranial, brachiocephalic branch)	Side Room	22.04
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	Side Room	22.04
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		3.02
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		3.02
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)		3.03, 22.05
6730	Venous sampling, adrenal, parathyroid, renal, etc.	Side Room	
6740	Venography (selective, catheter, single vessel study and/or venous sampling, I.V.C., S.V.C., adrenal, renal, hepatic)	Side Room	
7010	Needle biopsy (trans-thoracic, bone, abdominal)	Side Room	
7072	Nerve block for pain control, peripheral joints, under image guidance and confirmed by contrast injection	Side Room	
7073	Nerve block for pain control, spinal region, under image guidance and confirmed by contrast injection	Side Room	
7000	Myelogram	Side Room	
7005	Myelogram (direct lateral puncture, thoracic or cervical)	Side Room	

INTERVENTIONAL RADIOLOGY - PAYMENT RULES

22.01	This benefit is payable in addition to the surgery, at a separate operative session, for lesion(s) removal
22.02	50% benefit applies if carried out at the same session as breast surgery
22.03	• The Radiologist who performs the procedure must have specialised embolisation experience or undergone appropriate training and be registered with Irish Life Health. • All cases of uterine artery embolisation must be performed in a hospital listed in the Irish Life Health Directory of hospitals, by a consultant radiologist. • Benefit will not be made in the following circumstances: – where there is any evidence of current or recent infection in the genital tract – when a patient is unwilling to consent to hysterectomy if the embolisation procedure is complicated – If the above criteria are not satisfied in full
22.04	Includes angiographic evaluation before, during and immediately after the procedure, at the same session, following a full assessment of the patient in a multidisciplinary team, which involves one or more consultants in the following specialities: Dermatology, Plastic Surgery, Haematology and Interventional radiology
22.05	Benefit shown is payable in full with the code for the main procedure

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Radiograms

Alimentary Tract

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
6000	Plain film, abdomen		
6001	Plain film abdomen complete, including decubitus and/or erect views		
6005	Barium enema		20.02
6010	Barium enema, double contrast.		20.02
6020	Barium meal and follow through or small bowel study		20.01
6015	Barium meal and/or swallow - single contrast		20.01
6030	Barium swallow and meal - double contrast		20.01
6066	Defaecating proctogram		
6011	Barium enema, therapeutic for reduction of intussusception		
6045	Screening diaphragm		
607	0 T - tube cholangiogram		
6055	IV cholangiogram		

Chest

6078	Chest, PA, lateral and apical including ribs		
6090	Larynx		
6095	Sternum and chest		
6100	Thoracic inlet		

Joints and Long Bones

6115	Ankle		
6119	Ankle, complete, minimum of three views including inversion/eversion		
6121	Acromioclavicular joints, bilateral, with or without weight distraction		
6122	Knee, complete, including oblique(s), and tunnel, and/or patellar and/or standing views		
6120	Bone age		
6125	Calcaneum		
6130	Clavicle		
6135	Elbow		
6140	Femur		
6145	Finger/toe		
6150	Foot		
6155	Hand		
6165	Humerus		
6170	Knee		
6175	Limb length/orthopaedic measurement		
6180	Pelvis (inc. hips)		
6185	Radius and ulna		
6190	Sacro-iliac joints		
6195	Scaphoid		
6200	Scapula		
6205	Scoliosis series		
6210	Shoulder		
6215	Sternoclavicular joint		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
6220	Tibia and fibula		
6225	Wrist		

Obstetric

6580	Abdomen		
6585	Pelvimetry		

Skull

6590	Facial bones		
6595	Foramina optic		
6605	Mandible		
6610	Mastoid		
6620	Nasal bones		
6625	Nasal sinuses		
6630	Orbital views		
6635	Parotid gland		
6645	Skull		
6650	Temporomandibular joint		

Soft Tissue

6655	F.B. in eye and localisation		
6670	Radiological examination, surgical specimen		
6660	Mammogram		
6665	X-ray neck; for F.B. in trachea or oesophagus or acute infection (e.g. epiglottitis)		

Special Procedures

6685	Aortogram (arch/TLA, etc.)		
6690	Cavernosogram		
6705	Facet arthrogram (single level)		
6710	Portogram		
6725	Splenoportogram		
6735	Venogram, peripheral, single limb		

Spine

6745	Cervical		
6750	Coccyx		
6755	Complete spine		
6760	Dorsal (thoracic)		
6765	Lumbar		
6770	Sacrum		
6775	Scoliosis views		
6780	Skeletal survey		

Teeth

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
6785	Occlusal (Intra-Oral)		
6790	Pantomogram		
6795	Tooth, single		

Urinary Tract

6905	Cystogram		
6910	I.V.P.		
6915	Micturating cystogram		
6920	Straight renal tract (KUB)		
6925	Urethrogram		
6930	Vesiculogram		

Other Radiograms

6950	Antegrade pyelogram		
6955	Arthrogram		
6965	Bronchogram		
6970	Dacrocystogram		
6975	Discogram		
6885	Thyroid		
6991	Videofluoroscopy feeding study (paediatric)		
7011	Nephrostogram		
7020	Percutaneous transhepatic cholangiogram		
7025	Per-operative cholangiogram		
7034	Imaging supervision, interpretation and report for injection procedures during cardiac catheterisation; ventricular and/or atrial angiography. Encapsulates all guidance for the procedure including plain films		
7036	Radiological guidance during investigations or therapeutic procedure (use code 7034 for cardiology procedures) Encapsulates all guidance for the procedure including plain films		
7037	Radiological guidance for mammographic wire guided biopsy		
7040	Retrograde pyelogram		
7051	Sialogram, Parotid		
7052	Sialogram, Submandibular		
7055	Sinogram (injection of sinus tract, diagnostic)		
7065	Tomograms (+ area films)		
7070	Ventriculogram		
7071	Insertion of Contrast materials to interspinous 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		

NUCLEAR MEDICINE

Musculo Skeletal

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
6270	Limited joint scan		
6275	Multiple joint scan		
6280	Sacro-iliac joint uptake		
6290	Partial body bone scan		
6295	Whole body bone scan		
6300	3-Phase bone scan		
6305	SPECT (Tomo) bone scan		
6340	Gallium scan		

Central Nervous

6310	Static brain		
6315	Dynamic brain scan		
6320	SPECT brain (CBF, Ceretec, ECD, blood pool, DAT Scan)		
6325	Static - planar cysternogram		
6330	SPECT cysternogram		

Cardiovascular

6260	Aortogram		
6365	Blood pool scan (MUGA)		
6370	Exercise blood pool scan (EX. MUGA)		
6375	Dipyridamole thallium		
6380	Exercise thallium		
6395	SPECT anti-myosin scan		
6400	SPECT thallium		
6570	Venogram, unilateral		
6575	Venogram, bilateral		

Genitourinary

6415	Renogram		
6420	Combined renogram/GFR		
6430	Diuretic renogram		
6435	DMSA renal scan		
6440	Micturating cystogram		
6445	SPECT DMSA renal scan		
6550	Testicular scan		

Gastrointestinal

6235	Abdominal scan (Meckel's)		
6345	Gastric emptying		
6350	G.I. bleed		

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
6450	Colloid liver scan		
6455	HIDA liver scan		
6460	SPECT liver scan		
6465	Hepatic (liver) blood flow		
6545	Spleen scan		

Respiratory

6470	Aerosol lung scan		
6475	Gallium lung scan		
6480	Lung perfusion scan		
6485	Lung ventilation scan		
6490	SPECT lung scan		
6495	Ventilation/perfusion lung scan		

Endocrine

6410	Whole body iodine scan		
6520	MIBG scan		
6530	Parathyroid scan		
6531	SPECT parathyroid scan, dual phase		
6555	Technetium scan of thyroid		
6560	Iodine scan of thyroid		
6565	Thallium scan of thyroid		

Other Scans

6500	Lymphoscintigram		
6505	Marrow scan		
6240	White blood cell scan (WBC)		
6210	Shoulder		
6515	Monoclonal antibody scan - static		
6535	Platelet scan		
6501	Sentinel node(s) (scintigraphy)		
6573	Red cell survival		

ULTRASOUND

Non Invasive Vascular Studies

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
6812	Duplex scan of extracranial or intracranial arteries; unilateral or bilateral study		
6813	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or bilateral study		
6814	Duplex scan of upper extremity arteries or bypass grafts; unilateral or bilateral study		
6816	Duplex scan of extremity veins including response to compression and other manoeuvres; unilateral or bilateral study		
6817	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study		
6818	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study		
6819	Duplex scan of the extremity veins in patients with a diagnosis of cancer, where symptoms are suggestive of deep vein thrombosis		

Ultrasound

6805	Biliary		
6810	Breast		
6811	Chest		
6835	Eye		
6840	Hip		
6841	Knee		
6845	Obstetrical		
6846	Obstetrical (with full foetal assessment)		
6850	Paediatric cranial		
6855	Pelvis		
6857	Pleural space (for localisation)		
6860	Prostate, transrectal		
6865	Renal (kidneys)		
6870	Shoulder		
6875	Testicular		
6880	Transvaginal		
6885	Thyroid		
6890	Complete abdominal ultrasound		
6896	Paediatric spine (child of six months or younger)		

GENERAL SURGERY - PAYMENT RULES

20.01	Only one of procedure codes 6015, 6020 and 6030 are payable when performed on the same day		

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CT Codes

Without Contrast

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
6102	Brain, without contrast material		21.01
6101	Computed tomographic angiography, with or without contrast material(s), all sections including image post processing, pulmonary		
6104	Orbit, sella or outer, middle, or inner ear; without contrast material		21.01
6107	Maxillofacial area, without contrast material		21.01
6109	Thorax, without contrast material		
6111	CAT scanning for biopsy or drainage		
6113	High resolution, lungs		
6114	Abdomen (including pelvis)		21.02
6123	CT Colonography	Side Room	
6124	Ablation therapy for reduction or eradication of one or more pulmonary tumour(s) under CT guidance, including pleura or chest wall when involved by tumour extension, percutaneous, radiofrequency (benefit for CT guidance included) (I.P.)	I.P.	
6222	Computed tomographic (CT) coronary angiography, with or without contrast material(s), all sections, including image post processing	Diagnostic	
6223	C.T. scanogram of lower limbs (paediatric)		
6226	Long bones		
6227	Joints		
6228	Spine		
6229	Feet/Hands		

Please refer to Clinical indicators for Cardiac CT and CT Colonography.

With Contrast

6103	Brain, without contrast material		21.01
6101	Computed tomographic angiography, with or without contrast material(s), all sections including image post processing, pulmonary		
6106	Orbit, sella or outer, middle, or inner ear; without contrast material		21.01
6108	Maxillofacial area, without contrast material		21.01
6112	Thorax, without contrast material CAT scanning for biopsy or drainage High resolution, lungs		
6116	Abdomen (including pelvis)		21.02
6224	Spine		

CT CODES - PAYMENT RULES

21.01	Codes 6104, 6106, 6107 and 6108 are not payable with 6102 or 6103, if done at the same time
21.02	Code 6114 is not payable with 6116, if done at the same time

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Non Hospital

Irish Life Health Procedure List - Minor Procedure Fee

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1800	Epistaxis, anterior packing and/or cautery (I.P.)	I.P., Side Room/ Outpatient, Service	
2505	Foreign body, removal of, from conjunctiva	Side Room/ Outpatient, Service	
2520	Wounds, repair	Side Room/ Outpatient, Service	
3120	Nail, removal of	Side Room/ Outpatient, Service, Histology to a limit of €65	
3155	Whitlow, incision and drainage	Side Room/ Outpatient, Service	
4155	Avulsion of nail plate, partial or complete, simple	Side Room/ Outpatient, Service	
4160	Excision of nail and nail matrix, partial or complete (e.g. ingrown or deformed nail), for permanent removal	Side Room/ Outpatient, Service	
4332	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g. fingers, toes) (I.P.)	I.P., Side Room/ Outpatient, 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/ Outpatient, 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/ Outpatient, Service	
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/ Outpatient, Service	
1505	Abscess, cyst or tumour, aspiration of (I.P.)	I.P., Side Room/ Outpatient, Service	
1509	Biopsy of skin, subcutaneous tissue and/or mucous membrane including simple closure (I.P.)	I.P., Side Room/ Outpatient, Service	
1516	Destruction by cryotherapy, cautery and or curettage, of benign or pre malignant lesions; up to 5 lesions	I.P., Side Room/ Outpatient, Service	
1517	Destruction by cryotherapy, cautery and or curettage, of benign or pre malignant lesions; 6 or more lesions	I.P., Side Room/ Outpatient, Service	
1525	Foreign body, removal of	Side Room/ Outpatient, Service	

CODE	DESCRIPTION	PAYMENT INDICATORS	PAYMENT RULES
1540	Skin abscess, (superficial) incision and drainage of (I.P.)	I.P., Side Room/ Outpatient, Service	
1546	Enucleation of lipoma	I.P., Side Room/ Outpatient, Service	
1552	Surgical excision of benign lesion or lesions (includes sebaceous cysts) (I.P.)	I.P., Side Room/ Outpatient, 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/ Outpatient, Service, Histology to a limit of €66	
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/ Outpatient	15.05
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/ Outpatient	15.05
1641	Therapeutic phlebotomy for patients with polycythemia rubre vera or haemachromatosis, by the consultant physician.	Side Room/ Outpatient	
4210	Plantar warts, surgical excision, one or more (not local application, cryotherapy etc.)	Side Room/ Outpatient, Service	
49371	Excision of benign or malignant lesion(s), any area; adjacent tissue transfers or rearrangement, 4 sq. cm or less	Side Room/ Outpatient	
1191	Breast cyst(s) aspiration/fine needle biopsy (diagnostic or therapeutic) (I.P.)	I.P., Side Room/ Outpatient, Service	

Notes:

Consultant Non Hospital

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OPD Only

Recognised as OPD only

CODE	DESCRIPTION	SPECIALTY
1587	Laser treatment to port wine stains only, one or more sessions, plus photographic evidence to be supplied with claim	Skin and subcutaneous tissues
2147	CO2 response curve	Ear, nose and throat
2149	Body plethysmography	Ear, nose and throat
4321	Arthrocentesis, one or more injections at the same session, children aged 12 to 16; small, intermediate or large joint (I.P.)	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.)	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.)	Orthopaedic operations
4546	Keloids and hypertrophic scars intralesional injection of triamcinolone; up to and including the sixth lesions (I.P.)	Plastic surgery
5008	Cardiac ultrasound, (echocardiography) for patients on cytotoxic chemotherapy	Cardiological procedures
5022	Cardiovascular stress test with pharmaceutical/chemical agent(s) includes IV administration, echocardiography ECG with consultant cardiologist in constant attendance.	Cardiological procedures
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	Paediatric cardiology
5108	Cardiac ultrasound, (echocardiography)	Cardiological procedures
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	Paediatric cardiology
5940	Duplex ultrasound scan, unilateral or bilateral, only one claimable per anatomical site (e.g. for extracranial or intracranial arteries; unilateral or bilateral – one payment applies; for lower extremity arteries, one or both legs – one payment applies)	Skin and subcutaneous tissues
5940	Duplex ultrasound scan, unilateral or bilateral, only one claimable per anatomical site (e.g. for extracranial or intracranial arteries; unilateral or bilateral – one payment applies; for lower extremity arteries, one or both legs – one payment applies)	Skin and subcutaneous tissues

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Irish Life health

Information correct as of August 2014.

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