He Kaupare. He Manaaki.
He Whakaora.
prevention. care. recovery.

SERVICE SCHEDULE FOR ELECTIVE SURGERY SERVICES

CONTRACT NO: _____

A. QUICK REFERENCE INFORMATION

1. TERM FOR PROVIDING ELECTIVE SURGERY SERVICES

1.1 The term for the provision of Elective Surgery Services is the period from 1 November 2019 ("Start Date") until the close of 31 October 2024 ("End Date") or such earlier date upon which the period is lawfully terminated or cancelled.

1.2 ACC may in its sole discretion offer the Supplier an extension of up to 24 months and, if the Supplier agrees, the term will be extended by written agreement between the parties.

2. SERVICE LOCATION (PART B CLAUSE 4)

Facility Name	Location	Certification/Accreditation Type

3. NAMED PROVIDERS

3.1 Named Providers (PART B CLAUSE 17).

Last Name	First Name	Specialty or Category of Professional Registration	New Zealand Medical Council Number or Dental Council of New Zealand Number	ACC Provider Number

3.2 Named Red List Providers (PART B CLAUSE 17) [where applicable].

Last Name	First Name	Specialty or Category of Professional Registration, including Red List accreditation	New Zealand Medical Council Number or Dental Council of New Zealand Number	ACC Provider Number

4. SERVICE ITEMS AND PRICES (PART B CLAUSE 32)

Table 1: Core Service Items and Prices

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
3DIMAGE1	Full Price use of 3D Intraoperative imaging within Theatre for a total surgery time of 0 – 1 hour.	$1,264.14
3DIMAGE2	Full Price use of 3D Intraoperative imaging within Theatre for a total surgery time of 1 – 2 hours.	$1,364.31
3DIMAGE3	Full Price use of 3D Intraoperative imaging within Theatre for a total surgery time of 2 – 4 hours.	$1,664.78
3DIMAGE4	Full Price use of 3D Intraoperative imaging within Theatre for a total surgery time of 4 or more hours	$1,965.26
AFT100	Ankle Arthrodesis Simple - Open, includes minor bone graft	$10,484.06
AFT101	Ankle Arthrodesis Simple - Arthroscopic, includes minor bone graft	$11,127.44
AFT102	Ankle Arthrodesis Complex: Open– includes iliac crest graft, structural graft, Tendo Achilles (TA) procedures, osteotomy for access, removal metal ware	$12,933.64
AFT103	Ankle Arthrodesis Complex: Arthroscopic– includes iliac crest graft, structural graft, Tendo Achilles (TA) procedures, osteotomy for access, removal metal ware	$13,590.32
AFT104	Ankle Arthrodesis Revision: Includes bone graft, Tendo Achilles (TA) procedures, removal metal ware	$16,217.07
AFT105	Subtalar Arthrodesis Simple - Open (includes minor bone graft)	$10,484.06
AFT106	Subtalar Arthrodesis Simple - Arthroscopic includes minor bone graft	$10,799.11
AFT107	Subtalar Arthrodesis Complex: Includes bone graft, Tendo Achilles (TA) surgery, metal ware removal	$11,455.79
AFT108	Subtalar Arthrodesis Revision - Includes bone graft, Tendo Achilles (TA) release, metal ware removal	$16,217.07
AFT109	Triple Arthrodesis Simple - open includes minor bone graft	$12,112.48

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
AFT110	Triple Arthrodesis Simple - Arthroscopic (includes minor bone graft)	$12,769.16
AFT111	Triple Arthrodesis Complex: Includes bone graft, Tendo Achilles (TA) surgery, metal ware removal	$15,232.04
AFT112	Triple Arthrodesis Revision - Includes bone graft, Tendo Achilles (TA) release, metal ware removal	$16,217.07
AFT113	Talonavicular Arthrodesis Simple - Open (includes minor bone graft)	$8,593.77
AFT114	Talonavicular Arthrodesis Simple - Arthroscopic includes minor bone graft	$9,184.70
AFT115	Talonavicular Arthrodesis Complex: Includes bone graft, Tendo Achilles (TA) surgery, metal ware removal	$10,799.11
AFT116	Talonavicular Arthrodesis Revision - Includes bone graft, Tendo Achilles (TA) release, metal ware removal	$12,769.16
AFT117	Calcaneocuboid Arthrodesis Simple - Open (includes minor bone graft)	$8,593.77
AFT118	Calcaneocuboid Arthrodesis Simple - Arthroscopic includes minor bone graft	$9,184.70
AFT119	Calcaneocuboid Arthrodesis Complex: Includes bone graft, Tendo Achilles (TA) surgery, metal ware removal	$10,799.11
AFT120	Calcaneocuboid Arthrodesis Revision - Includes bone graft, Tendo Achilles (TA) release, metal ware removal	$12,769.16
AFT121	Double Arthrodesis Simple - open includes minor bone graft	$11,455.79
AFT122	Double Arthrodesis Simple - Arthroscopic (includes minor bone graft)	$12,112.48
AFT123	Double Arthrodesis Complex: Includes bone graft, Tendo Achilles (TA) surgery, metal ware removal	$13,508.08
AFT124	Double Arthrodesis Revision - Includes bone graft, Tendo Achilles (TA) release, metal ware removal	$15,560.37
AFT125	Tibio-talo-calcaneal (TTC) Arthrodesis Simple - open includes minor bone graft	$13,425.84
AFT126	Tibio-talo-calcaneal (TTC) Arthrodesis Simple - Arthroscopic (includes minor bone graft)	$13,425.84
AFT127	Tibio-talo-calcaneal (TTC) Arthrodesis Complex: Includes bone graft, Tendo Achilles (TA) surgery, metal ware removal	$16,873.75
AFT128	Tibio-talo-calcaneal (TTC) Arthrodesis Revision - Includes bone graft, Tendo Achilles (TA) release, metal ware removal	$18,843.82
AFT129	Navicular Cuneiform (N-C) Arthrodesis Simple - Open single joint (includes minor bone graft)	$8,586.01

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
AFT130	Navicular Cuneiform (N-C) Arthrodesis Complex: Multiple joints Includes bone graft, Tendo Achilles (TA) surgery, metal ware removal	$10,799.11
AFT131	Navicular Cuneiform (N-C) Arthrodesis Revision - Includes bone graft, Tendo Achilles (TA) release, metal ware removal	$12,769.16
AFT132	Tarsometatarsal (TMT) Arthrodesis Simple - Open single joint (includes minor bone graft)	$7,640.86
AFT133	Tarsometatarsal (TMT) Arthrodesis Complex: Multiple joints Includes bone graft, Tendo Achilles (TA) surgery, metal ware removal	$12,769.16
AFT134	Tarsometatarsal (TMT) Arthrodesis Revision - Includes bone graft, Tendo Achilles (TA) release, metal ware removal	$14,082.54
AFT135	Metatarsophalangeal (MTP) Arthrodesis Simple - (includes minor bone graft)	$8,278.74
AFT136	Metatarsophalangeal (MTP) Arthrodesis Complex: Includes bone graft, structural graft, Tendon surgery, metal ware removal	$9,538.91
AFT137	Metatarsophalangeal (MTP) Arthrodesis Revision - Includes bone graft, tendon release, metal ware removal	$12,112.48
AFT138	PIP / DIP Arthrodesis Simple- 1-2 Toes (Proximal interphalangeal/Distal interphalangeal)	$5,435.53
AFT139	PIP/DIP Arthrodesis Complex: Multiple 3+ toes (Proximal interphalangeal/Distal interphalangeal)	$7,325.83
AFT140	PIP/DIP Arthrodesis Revision - Includes bone graft, tendon release, metal ware removal (Proximal interphalangeal/Distal interphalangeal)	$7,955.91
AFT141	Tarsal Coalition - Excision and interposition graft	$6,061.12
AFT142	Distal Tibial Osteotomy - Simple. Includes internal fixation, bone graft, tendon release	$9,971.23
AFT143	Distal Tibial Osteotomy - Complex. Includes internal fixation, bone graft, fibula osteotomy, tendon release	$12,311.98
AFT144	Distal Tibial Osteotomy -Revision. Includes internal fixation, bone graft, tendon release and metal ware removal	$15,595.40
AFT145	Distal Fibular Osteotomy - Simple. Includes internal fixation, cancellous bone graft	$9,656.20
AFT146	Distal Fibular Osteotomy - Complex. Includes internal fixation, structural bone graft, tendon release	$12,311.98
AFT147	Distal Fibular Osteotomy -Revision. Includes internal fixation, bone graft, tendon release and metal ware removal	$14,282.04
AFT148	Calcaneal Osteotomy - Simple. Includes internal fixation	$6,813.00

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
AFT149	Calcaneal Osteotomy Complex - Hind foot reconstruction. Includes internal fixation, gastrocnemius slide or Tendo Achilles (TA) lengthening, tendon transfer	$14,282.04
AFT150	Midtarsal Osteotomy	$6,182.93
AFT151	1st Metatarsal Osteotomy Simple - include internal fixation	$6,813.00
AFT152	1st Metatarsal Osteotomy Complex - include exostectomy, internal fixation, MTP release and realignment, bone graft	$7,443.11
AFT153	1st Metatarsal Osteotomy Revision - include exostectomy, bone graft, internal fixation, MTP release and realignment, metal ware removal, Tendo Achilles (TA) lengthening/gastrocnemius slide	$10,286.27
AFT154	Lesser Metatarsal Osteotomy - Single. Includes fixation and bonegraft	$6,813.00
AFT155	Lesser Metatarsal Osteotomy - Multiple. Includes fixation and bonegraft	$8,396.01
AFT156	Lesser Metatarsal Osteotomy Revision - Single, includes fixation and bonegraft, removal metal ware	$9,963.47
AFT157	Lesser Metatarsal Osteotomy Revision - Multiple. Includes fixation and bonegraft, removal metal ware	$11,573.04
AFT158	Phalangeal Osteotomy - Single. Includes fixation and bonegraft	$5,552.82
AFT159	Phalangeal Osteotomy - Multiple. Includes fixation and bonegraft	$7,758.13
AFT160	Phalangeal Osteotomy Revision - Single, includes fixation and bonegraft, removal metal ware	$8,703.29
AFT161	Phalangeal Osteotomy Revision - Multiple. Includes fixation and bonegraft, removal metal ware	$10,593.54
AFT162	Tenotomy of tendon ankle, foot or toe - Single: Percutaneous	$3,855.79
AFT163	Tenotomy of tendon ankle, foot or toe - Single: Open	$5,431.03
AFT164	Tenotomy of tendon of ankle, foot or toe: - Multiple: Percutaneous	$4,485.90
AFT165	Tenotomy of tendon of ankle, foot or toe: - Multiple: Open	$6,691.21
AFT166	Tenolysis of tendon ankle, foot or toe: - Single	$5,431.03
AFT167	Tenolysis of tendon ankle, foot or toe: - Multiple	$6,691.21
AFT168	Tendon Repair of foot: - Single	$5,431.03
AFT169	Tendon Repair of foot: - Multiple	$6,691.21
AFT170	Tendon Repair of Toe: Single	$5,431.03
AFT171	Tendon Repair of Toe: - Multiple	$6,691.21

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
AFT172	Amputation toe - MTP/IP/ DIP joint – Single	$5,431.03
AFT173	Amputation toe - MTP/IP/DIP joint - Multiple more than 2 toes including bilateral	$7,006.27
AFT174	Trans metatarsal amputation	$9,656.20
AFT175	Mid foot amputation	$9,656.20
AFT176	Hind foot amputation	$9,656.20
AFT177	Joint release for claw toe - single	$5,115.99
AFT178	Joint release for claw toe - multiple	$6,376.17
AFT179	Tendo Achilles Repair Simple: Early (<6wks)	$6,383.94
AFT180	Tendo Achilles Repair - Complex: Delayed (>6wks) Includes any debridement, lengthening and/or shortening	$8,274.21
AFT181	Tendo Achilles Reconstruction - Complex - delayed reconstruction: Includes harvesting of graft and any debridement, lengthening and/or gastrocnemius slide, tendon transfer	$10,164.49
AFT182	Tendo Achilles Debridement	$5,431.03
AFT183	Tendo Achilles Lengthening - Percutaneous	$5,115.99
AFT184	Tendo Achilles Lengthening - Open	$8,274.21
AFT185	Tendo Achilles Gastrocnemius Slide	$6,061.12
AFT186	Plantar Plate Repair -Single. Includes metatarsal osteotomy, internal fixation, collateral ligament repair	$7,955.91
AFT187	Plantar Plate Repair -Multiple. Includes metatarsal osteotomy, internal fixation, collateral ligament repair	$10,804.62
AFT189	Tendon Transfer Tibialis anterior	$8,274.21
AFT190	Tendon Transfer Tibialis posterior	$8,274.21
AFT191	Tendon Transfer involving FDL, FHL or peroneal tendons (Flexor Digitorum Longus, Flexor Hallucis Longus)	$7,329.09
AFT192	Tendon Transfer Toe - Single. Includes split transfers	$6,061.12
AFT193	Tendon Transfer Toes - 2-3. Includes split transfers	$7,006.27
AFT194	Tendon Transfer Toes - > 3. Includes split transfers	$7,951.40
AFT195	Repair Flexor Tendon Ankle	$6,691.21
AFT196	Repair Extensor Tendon Ankle	$6,376.17
AFT197	Peroneal tendon Stabilisation - Simple. Includes peroneal retinaculum repair, peroneal tendon repair	$7,006.27
AFT198	Peroneal tendon Stabilisation - Complex. Includes Retinacular repair, peroneal tendon repair, groove deepening, retinacular recon with graft	$10,164.49

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
AFT199	Ankle Lateral Ligament Reconstruction -Simple. Includes Brostrum / Gould	$7,329.09
AFT200	Ankle Lateral Ligament Reconstruction - Complex. Includes Graft, split tendon reconstruction	$8,904.32
AFT201	Ankle Lateral Ligament Reconstruction - Revision. Includes Graft, split tendon reconstruction, removal implants	$10,164.49
AFT202	Ankle Medial Ligament Reconstruction -Simple.	$7,329.09
AFT203	Ankle Medial Ligament Reconstruction - Complex. Includes Graft, split tendon reconstruction	$8,904.32
AFT204	Ankle Medial Ligament Reconstruction - Revision. Includes Graft, split tendon reconstruction, removal implants	$10,164.49
AFT205	Ankle Spring ligament reconstruction - Simple	$7,329.09
AFT206	Ankle Spring ligament reconstruction - Complex. Includes spilt tendon, graft	$8,904.32
AFT207	Subtalar ligament reconstruction - Simple	$7,329.09
AFT208	Subtalar ligament reconstruction - Complex. Includes spilt tendon, graft	$8,904.32
AFT209	Syndesmosis stabilisation - Simple. Early less than 6wks, primary repair, includes fixation	$7,644.12
AFT210	Syndesmosis stabilisation - Complex. Late more than 6wks. Includes debridement, graft and fixation	$10,164.49
AFT211	Syndesmosis fusion. Includes bone graft and fixation	$12,134.55
AFT212	Plantar Fascia Release	$5,115.99
AFT213	Decompression Fasciotomy Foot	$6,383.94
AFT214	Tarsal Tunnel Release - Includes neurolysis	$5,753.85
AFT215	Total Ankle replacement - Simple.	$17,591.82
AFT216	Total Ankle replacement - Complex. Includes debridement Tendo Achilles (TA) lengthening/gastrocnemius slide, removal metalware	$19,561.88
AFT220	ORIF Calcaneus - Simple. Anterior process and tubercle avulsion (Open reduction internal fixation)	$7,018.55
AFT221	ORIF Calcaneus - Complex. Includes bone graft	$9,647.75
AFT222	ORIF talus fracture - Simple	$7,018.55
AFT223	ORIF talus fracture - Complex. Includes bone graft, osteotomy	$10,277.83
AFT224	ORIF Other Tarsal fracture - Simple. Single bone	$6,695.72
AFT225	ORIF Other Tarsal fracture - Complex. Multiple bones	$10,277.83
AFT226	ORIF uni-malleolar fracture	$7,018.55

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
AFT227	ORIF bi-malleolar fracture	$8,908.83
AFT228	ORIF Trimalleolar fracture	$10,799.11
AFT229	ORIF metatarsal fracture - Single	$6,695.72
AFT230	ORIF metatarsal fracture - Multiple	$8,908.83
AFT231	ORIF of Lisfranc fracture/dislocation - Simple 1-2 joints	$7,963.69
AFT232	ORIF of Lisfranc fracture/dislocation - Complex >2 joints	$11,538.02
AFT233	ORIF phalanx fracture -Single	$5,750.58
AFT234	ORIF phalanx fracture - Multiple	$7,640.86
AFT250	Arthroscopy Ankle + additional procedure simple - Anterior OR Posterior - includes: Biopsy synovium Loose body / osteochondral fragment removal Chondral debridement Soft tissue impingement debridement	$6,656.58
AFT251	Arthroscopy Ankle proceed to open surgery- simple - Anterior OR Posterior - includes: Biopsy synovium Loose body / osteochondral fragment removal Chondral debridement Soft tissue impingement debridement	$7,609.49
AFT252	Ankle open surgery - simple- Anterior OR Posterior - includes: Biopsy synovium, and/or ganglion Loose body/osteophyte, and/or osteochondral fragment or lesion Excision of os trigonum, and/or ganglion Chondral debridement Soft tissue impingement debridement	$6,341.54
AFT260	Arthroscopy Ankle + additional procedure - Complex 1 – Anterior OR Posterior - includes any combination of procedures found in AFT250 or one of the following procedures Synovectomy Microfracture and debridement OCL Talus / Tibia Internal fixation fragment Debridement syndesmosis Removal os trigonum Debridement bony impingement spurs	$7,286.67
AFT261	Arthroscopy Ankle proceed to open surgery - Complex 1 - Anterior OR Posterior - includes any combination of procedures found in AFT250 together with any	$8,554.63

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	procedures found in AFT251 or one of the following procedures Synovectomy Internal fixation of os trigonum Microfracture and debridement OCL Talus / Tibia Internal fixation osteochondral fragment	
AFT262	Ankle Open Surgery - Complex 1 – Anterior OR Posterior - includes any combination of procedures found in AFT252 or one of the following procedures Internal fixation of os trigonum Microfracture and debridement OCL Talus / Tibia Internal fixation osteochondral fragment	$7,609.49
AFT270	Arthroscopy Ankle Complex 2 - Anterior OR Posterior - includes: any combination of procedures found under AFT250 and AFT260	$7,916.77
AFT271	Arthroscopy Ankle proceed to open surgery - Complex 2 - Anterior OR Posterior - includes: any AFT251 and AFT261 procedures or these in combination with AFT250 or AFT260 procedures	$8,861.90
AFT272	Ankle open surgery - Complex 2 - Anterior OR Posterior - includes: any combination of procedures found under AFT252 and AFT262	$7,916.77
AFT280	Arthroscopy Ankle - Complex 3 - requiring Anterior AND Posterior approach - Includes: any combination of procedures found under AFT250 and AFT260	$11,416.65
AFT281	Arthroscopy Ankle proceed to open surgery - Complex 3 - requiring Anterior AND Posterior approach. Includes: any combination of procedures found in AFT251 and AFT261 or these in combination with AFT250 or AFT260 procedures	$11,416.65
AFT282	Ankle open surgery - Complex 3 - requiring Anterior AND Posterior approach - Includes: any combination of procedures found under AFT252 and AFT262	$10,759.96
AFT290	Arthroscopy Ankle in combination with stabilisation procedures	$9,499.77
AFT295	Arthroscopy Ankle in combination with augmentation procedures	$10,759.96
AFT300	Botox for release of spasm/contractures 1 body site May be used as an equivalent for other body sites. Does not include costs for botox ampoules. These are billed separately using the addon block AFTBOTOX (see below)	$3,545.23
AFT301	Botox for release of spasm/contractures 2 body sites May be used as an equivalent for other body sites. Does not include costs for botox ampoules. These are	$3,860.27

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	billed separately using the add-on block AFTBOTOX (see below)	
AFT302	Botox for release of spasm/contractures 3 body sites May be used as an equivalent for other body sites. Does not include costs for botox ampoules. These are billed separately using the add-on block AFTBOTOX (see below)	$4,175.32
AFT303	Botox for release of spasm/contractures 4 or more body sites May be used as an equivalent for other body sites. Does not include costs for botox ampoules. These are billed separately using the add-on block AFTBOTOX (see below)	$4,490.37
AFTABOTX	Orthopaedic botox. For costs of botox ampoules used with the codes AFT300 - AFT303	Actual and Reasonable Cost
DNS01	Intra-oral Dental Implant x 1- stage 1 (includes bone graft)	$5,248.15
DNS02	Intra-oral Dental Implant x 2 - stage 1 (includes bone graft)	$7,218.58
DNS03	Bone Graft - Alveolar Osseous	$5,409.32
DNS04	Surgical Extraction of Teeth	$3,601.91
DNS06	Removal of Metal ware – Wire, Screw or Plate	$3,925.24
ELF01	Excision Un-united Olecranon Process	$4,605.86
ELF02	Excision Radial Head	$4,223.58
ELF03	Arthroplasty - Radial Head	$5,941.70
ELF06	Epicondylitis Release	$3,803.86
ELF07	Ulnar Nerve Transposition - Elbow	$4,999.88
ELF08	Posterior Interosseus Nerve Release for Radial Tunnel Syndrome	$5,021.17
ELF09	ORIF Fracture Radius or Ulna	$6,167.19
ELF10	Total Elbow Replacement	$16,499.72
ELF11	Reconstr. /Corrective Osteotomy Radius	$6,465.46
ELF21	Removal of plate and screws – Radius, includes excision/revision of initial scar including hypertrophic or keloid scarring	$4,216.12
ELF22	Removal of plate and screws – Ulna, includes excision/revision of initial scar including hypertrophic or keloid scarring	$4,216.12
ELF23	Removal of Flexible Intramedullary Nail - Radius/Ulna (includes Titanium Elastic Nail (TEN) includes excision/revision of initial scar including hypertrophic or keloid scarring)	$3,782.55

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
ELF24	Removal of Tension Band Wiring Elbow includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,782.55
ELF25	Distal Biceps tendon repair	$6,672.05
ELF50	Elbow Arthroscopic Surgery - Simple	$6,015.41
ELF51	Elbow Arthroscopy Proceed to Open Surgery - Simple	$6,968.67
ELF52	Elbow Open Surgery - Simple	$5,350.06
ELF60	Elbow Arthroscopic Surgery - Complex	$7,361.70
ELF61	Elbow Arthroscopy Proceed to Open Surgery - Complex	$7,355.17
ELF62	Elbow Open Surgery - Complex	$6,420.09
GNS01	Inguinal Hernia Repair (unilateral)	$5,358.40
GNS02	Incisional Hernia Repair	$7,523.44
GNS03	Laparosc. Ing. Hernia Repair - Prim. /Recurr. (unilateral)	$6,752.65
GNS04	Umbilical Hernia Repair	$5,275.90
GNS05	Femoral Hernia Repair (unilateral)	$4,978.95
GNS06	Ventral Hernia Repair	$5,571.80
GOP01	Bone Graft - any area, minor or small *from a site other than the initial surgical site	$5,935.56
GOP02	Bone Graft - any area, major *from a site other than the initial surgical site	$6,488.63
GOP03	Excision Exostosis - superficial	$4,345.80
GOP04	Excision Exostosis - deep	$5,199.95
GOP05	Excision Bursa (not to be used for excision ganglion)	$4,380.07
GOP07	Diagnostic Arthroscopy any joint (excluding wrist and hip)	$4,046.58
GOP20	Removal of plate and screws not elsewhere specified, includes excision/revision of initial scar including hypertrophic or keloid scarring	$4,216.12
GOP21	Removal of screws not elsewhere specified x 1-3, includes removal of diastasis screws, includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,782.55
GOP22	Removal wires/pins not elsewhere specified 1-3, includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,782.55
GOP23	Removal wires/pins not elsewhere specified >3, includes excision/revision of initial scar including hypertrophic or keloid scarring	$4,160.79
GOP24	Removal screws not elsewhere specified >3, includes removal of diastasis screws, includes excision/revision of initial scar including hypertrophic or keloid scarring	$4,539.06

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
HIT01	Total Hip Replacement (not to be used for hip resurfacing)	$14,923.63
HIT02	Hemi-arthroplasty (Partial Hip Replacement)	$12,210.49
HIT03	Revision Hip Replacement	$17,701.99
HIT05	ORIF Fracture Femur	$14,544.74
HIT06	Osteotomy - Distal Femur with Fixation	$9,441.81
HIT07	Adductor/Hamstring Tendon Release, Percutaneous	$3,191.04
HIT08	Lateral Cutaneous Nerve of Thigh Release	$3,012.74
HIT09	Decompression Fasciotomy - Thigh/Knee	$6,423.74
HIT17	Primary Removal Compression Hip screw and plate includes excision/revision of initial scar including hypertrophic or keloid scarring	$6,392.29
HIT18	Primary Removal of Cannulated Hip screws (not to be used in combination with Hip Arthroplasty), includes excision/revision of initial scar including hypertrophic or keloid scarring	$5,295.58
HIT19	Intraoperative Removal of Cannulated Hip screws (for use in combination with Hip Arthroplasty), includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,782.55
HIT20	Primary Removal of plate and screws Femur includes excision/revision of initial scar including hypertrophic or keloid scarring	$6,924.98
HIT21	Removal Intramedullary Femoral Rod (includes removal of all locking screws at time of procedure), includes excision/revision of initial scar including hypertrophic or keloid scarring	$7,457.64
HIT22	Removal Intramedullary Femoral Rod Locking Screws x 1-3 (not to be used in combination with Removal of Intramedullary Femoral Rod), includes excision/revision of initial scar including hypertrophic or keloid scarring	$4,539.06
HIT50A	Hip Arthroscopy simple	$10,626.16
HIT60A	Hip Arthroscopy Complex 1	$13,146.52
HIT70A	Hip Arthroscopic Surgery - Complex 2	$14,007.58
IMAGE1	Use of Image intensifier within Theatre for up to 30 minutes	$163.71
IMAGE2	Use of Image intensifier within Theatre for between 31 and 60 minutes.	$281.47
IMAGE3	Use of Image intensifier within Theatre for between 61 and 90 minutes.	$399.26
IMAGE4	Use of Image intensifier within Theatre for between 91 and 120 minutes.	$517.04

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
IMAGE5	Use of Image intensifier within Theatre for 121 and 150 minutes.	$634.82
KNE01	MUA - Knee Joint +/- injection If used in combination with other codes good reasoning must be supplied	$2,913.57
KNE03	Reconstruction Collateral Ligament	$6,849.02
KNE07	Patellectomy	$6,125.47
KNE09	Primary Total Knee Replacement Includes removal of ACL screws/metalware at the time of operation	$15,820.41
KNE10	Partial Knee Replacement (hemiarthroplasty – e.g. Oxford) Includes removal of ACL screws/metalware at the time of operation	$14,213.07
KNE11	Revision Total Knee Replacement Single stage revision (can be used for revision of a hemiarthroplasty) Not to be used for: Staged Revision or for bearing exchange and/or patella resurfacing (Staged Revision is Non-Core; Bearing exchange and/or patella resurfacing is KNE99) Includes removal of existing implants	$16,035.33
KNE12	Arthrodesis Knee	$10,105.00
KNE124	Repair of Patella Tendon – primary. Not to be used in combination with KNE128 and/or KNE129 and/or KNE130	$6,192.17
KNE125	Patella Tendon Reconstruction (includes harvesting of graft) Not to be used in combination with KNE128 and/or KNE129 and/or KNE130	$8,049.81
KNE128	Arthroscopic examination of the patellofemoral joint AND open or arthroscopic Patella realignment - soft tissue repair/reconstruction Simple Includes any procedure found in a KNE50, KNE51, KNE52 AND 1. Primary repair of medial retinacular soft tissues including tightening suturing 2. Vastus medialis obliquus (VMO) muscle advancement 3. Lateral Release 4. Treatment of articular cartilage	$9,787.43
KNE129	Arthroscopic examination of the patellofemoral joint	$13,660.57

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	AND open or arthroscopic Patella realignment - soft tissue repair/reconstruction Complex Includes any procedure found in a KNE128 AND Medial Patellofemoral Ligament Reconstruction with Graft includes harvesting and preparation; tunnel drilling; graft. Cannot be used in combination with KNE130	
KNE13	ORIF # Tibia or Fibula (includes tibial plateau fracture)	$8,065.37
KNE130	Arthroscopic examination of the patellofemoral joint AND Patella Realignment – Reconstruction/distal realignment bony procedure Includes any procedure found in a KNE128 AND Tibial tubercle realignment – includes tibial tubercle transfer medially and/or distally and internal fixation +/- excision lateral patellar osteophyte Cannot be used in combination with KNE129	$13,660.57
KNE14	Amputation - Below Knee	$10,672.12
KNE15	Revision of Below Knee Amputation (not to be used as an equivalent code)	$5,590.90
KNE16	Osteotomy - Proximal Tibia with Fixation (not to be used in combination with KNE124, KNE125, KNE128 and/or KNE129 and/or KNE130 Not to be used for Tibial Tubercle Transfer	$10,360.11
KNE17	Lateral Popliteal Nerve Decompression	$3,655.73
KNE18	Fasciotomy Calf	$4,527.52
KNE20	Removal of plate and screws Tibia includes removal of diastasis screws) Includes: any excision/revision of initial scar including hypertrophic or keloid scarring	$4,216.12
KNE21	Removal of Intramedullary Tibial Rod (includes removal of all locking screws at time of procedure). Includes: any excision/revision of initial scar including hypertrophic or keloid scarring	$6,839.92
KNE22	Removal of Locking Screws from Intramedullary Tibial Rod (includes removal of any number of locking screws at time of procedure) Not to be used in combination with KNE21 - Removal of Intramedullary Tibial Rod Includes: any excision/revision of initial scar including hypertrophic or keloid scarring.	$4,160.79
KNE23	Removal of Tension Wiring Patella. Includes: any excision/revision of initial scar including hypertrophic or keloid scarring	$3,782.55

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
KNE28	Extra-articular tenodesis/anterolateral ligament reconstruction for ACL instability (open with graft)	$6,849.02
KNE50	Knee Arthroscopic Surgery – Simple Includes Arthroscopy of the Knee and chondral debridement with one of the following listed procedures: • Arthroscopic Biopsy synovium or • Arthroscopic removal of loose bodies or • Arthroscopic removal of osteophytes or • Arthroscopic Meniscectomy medial and/or lateral or • Arthroscopic Plica Excision or • Arthroscopic Excision of intra-articular scar or • Arthroscopic Fat Pad excision or • Arthroscopic notchplasty and excision of any ACL remnants or • Arthroscopic Patella tendon debridement or • Arthroscopic lateral Retinacular release or • Arthroscopic meniscal cyst drainage	$5,012.85
KNE51	Knee Arthroscopy Proceed to Open Surgery – Simple includes: Arthroscopy of the Knee and Arthrotomy of the Knee and chondral debridement with one of the following listed procedures: • Biopsy synovium or • Removal of loose bodies or • Removal of osteophytes or • Meniscectomy medial and/or lateral or • Plica Excision or • Excision of intra-articular scar or • Fat Pad excision or • Notchplasty and excision of any ACL remnants or • Patella tendon debridement or • Lateral Retinacular release or • Meniscal cyst drainage	$10,863.17
KNE52	Knee Open surgery – Simple Includes: Arthrotomy of the knee and chondral debridement with one of the following listed procedures:	$6,816.58

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	• Biopsy synovium or • Removal of loose bodies or • Removal of osteophytes or • Meniscectomy medial and/or lateral or • Plica Excision or • Excision of intra-articular scar or • Fat Pad excision or • Notchplasty and excision of any ACL remnants or • Patella tendon debridement or • Lateral Retinacular release or • Meniscal cyst drainage	
KNE60	Knee Arthroscopic Surgery - Complex 1 Complex 1 Includes more than one procedure listed under KNE50 OR one of the following listed procedures: • Arthroscopic Meniscal repair • Arthroscopic Grade III - IV Chondroplasty (drilling or microfracture) • Arthroscopic Synovectomy	$6,134.73
KNE61	Knee Arthroscopy - Proceed to Open Surgery - Complex 1 Complex 1 – Includes more than one procedure listed under KNE51 OR one of the following listed procedures: • Meniscal repair • Grade III - IV Chondroplasty (drilling or microfracture) • Synovectomy	$11,829.41
KNE62	Knee Open Surgery - Complex 1 Includes more than one procedure listed under KNE52 OR one of the following listed procedures: • Open Meniscal Repair • Open Grade III-IV Chondroplasty (drilling or microfracture) • Open synovectomy	$8,179.88
KNE66	Meniscal Root Repair (arthroscopic)	$7,466.73
KNE70	Knee Arthroscopic Surgery – Complex 2 Includes: more than one procedure listed under KNE50 AND one or more of the procedures listed under KNE60 OR More than one procedure listed under KNE60	$7,466.73
KNE71	Knee Arthroscopic Surgery – Complex 2	$12,951.30

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	Includes: more than one procedure listed under KNE51 AND one or more of the procedures listed under KNE61 OR More than one procedure listed under KNE61	
KNE72	Knee Arthroscopic Surgery – Complex 2 Includes: more than one procedure listed under KNE52 AND one or more of the procedures listed under KNE62 OR More than one procedure listed under KNE62	$9,543.22
KNE81	Primary Knee ACL reconstruction (Anterior Cruciate Ligament) Primary and Simple: Arthroscopic and/or Open. Allograft is not to be used in this procedure except for when the reconstruction involves multiple ligament transfers, and/or the patient has a medical condition that precludes the use of autograft tissue	$11,383.82
KNE83	Revision Knee ACL Reconstruction (Anterior Cruciate Ligament) Simple: arthroscopic and/or open	$12,896.84
KNE85A	Primary Knee PCL reconstruction (Posterior Cruciate Ligament) – arthroscopic and/or open – Simple Includes: Harvesting, preparation of GRAFT and any combination of: Chondral debridement irrespective of Grade (including notchplasty, chondromalacia) and/or debridement of any soft tissue impingement (including Patella Tendon, ganglion, Hoffa's fat pad) and/or loose body removal and/or Meniscal debridement and/or lateral retinacular release	$15,947.79
KNE91	Primary Knee ACL Reconstruction (Anterior Cruciate Ligament) Complex Includes a KNE81 with Meniscal Repair &/or Outerbridge drilling. Allograft is not to be used in this procedure except for when the reconstruction involves multiple ligament transfers, and/or the patient has a medical condition that precludes the use of autograft tissue	$13,660.57
KNE93	Revision Knee ACL Reconstruction (Anterior Cruciate Ligament) Complex Includes a KNE83 with Meniscal Repair &/or Outerbridge III-IV drilling or microfracture	$15,476.20
KNE95A	Primary Knee PCL reconstruction (Posterior Cruciate Ligament) – arthroscopic and/or open – Complex	$18,249.54

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	Includes a KNE85A with Meniscal Repair &/or Outerbridge III-IV drilling or microfracture	
NRV01	Delayed Repair of Major Nerve	$7,781.39
NRV02	Delayed Repair of Digital Nerve	$4,818.28
NRV03	Excision of Neuroma	$4,385.66
NRV04	Reconstruction Digital Nerve with Nerve Graft	$10,321.00
NRV05	Reconstruction Single Major Nerve with Nerve Grafts	$12,250.46
NRV06	Neurolysis	$4,590.38
NRV07	Suture of Nerve requiring extensive mobilisation	$7,550.90
NRV09	Excision of Neurofibroma Major Peripheral Nerve	$6,345.81
OPT04	YAG Laser Capsulotomy	$1,582.12
OPT05	Repair of Blepharoptosis	$3,749.52
OPT06	Lid/Adnexa - lid surgery - minor	$2,949.69
OPT07	Lid/Adnexa - lid surgery - major	$4,121.64
OPT08	Dacryocystorhinostomy with intubation	$6,286.23
OPT09	Strabismus Surgery - one muscle	$3,032.02
OPT10	Strabismus Surgery - two muscles	$3,860.76
OPT101	Cataract Extraction Simple – Phacoemulsion + Insertion of Intraocular lens (IOL)	$4,859.50
OPT102	Cataract Surgery – including capsule stains with specialised OVDs (ophthalmic viscoelastic devices)	$4,960.55
OPT103	Cataract Surgery – includes capsule stains with specialised OVDs (ophthalmic viscoelastic devices) and/or: • Iris hooks/pupil expanders – and/or • Division of synechiae/iridoplasty and/or • Capsular ring	$5,590.64
OPT104	Cataract Surgery - includes procedures under OPT103 plus: • Limited anterior vitrectomy and/or • Sutured segments/rings and/or • Scleral sutured Intraocular lens (IOL)	$7,604.86
OPT105	Cataract Surgery - includes procedures under OPT103 and OPT104 plus: • Sutured iris repair and/or • Intracapsular iris segments and/or • Aniridic intraocular lens and/or • Artificial iris	$8,234.96
OPT106	Cataract Surgery – Includes procedures under OPT103 plus:	$8,865.03

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	• Endothelial corneal transplant DMEK (Descemet Membrane Endothelial Keratoplasty) and/or • Endothelial corneal transplant DSAEK (Descemet's stripping automated endothelial keratoplasty) and/or • Penetrating corneal transplant	
OPT107	Cataract Surgery – Includes procedures under OPT103 plus: • Glaucoma drainage surgery – trabeculectomy • OR • Glaucoma drainage surgery – tube or seton surgery	$6,220.73
OPT11	Strabismus Surgery - more than two muscles	$4,689.47
OPT120	Cataract Surgery – Revision – Includes: • Anterior Vitrectomy and/or - Pupilloplasty	$6,029.65
OPT121	Cataract Surgery – Revision – Includes: • Intra-ocular Lens Intraocular lens (IOL) repositioning and/or Anterior Vitrectomy	$6,029.65
OPT122	Cataract Surgery – Revision – Includes: • Intra-ocular Lens Intraocular lens (IOL) replacement and/or Anterior Vitrectomy	$6,029.65
OPT123	Cataract Surgery – Revision – Including: Mechanical Capsulotomy • to address Posterior Capsule Opacification	$4,960.55
OPT13	Phototherapeutic Keratectomy (PTK)	$3,426.52
OPT130	Cataract Surgery combined with Vitreo-retinal surgery - Including: • Posterior Vitrectomy	$6,496.08
OPT131	Cataract Surgery combined with posterior vitrectomy • Including: Intraocular lens (IOL) repositioning	$5,584.65
OPT132	Cataract Surgery combined with posterior vitrectomy • Including: pupilloplasty	$5,584.65
OPT133	Cataract Surgery combined with posterior vitrectomy • Including: sutured Intraocular lens (IOL)	$5,584.65
OPT14	Trabeculectomy with Antimetabolite Application	$6,459.02
OPT15	Enucleation/Evisceration with implant	$7,702.85
OPTAEYEB	National Eye Bank fee. Add on to be used in conjunction with OPT106	Actual and Reasonable Cost
OPTAFRAG	Fragmatome Use. Add on to be used in conjunction with OPT101-OPT133.	Actual and Reasonable Cost

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
ORAMAJB	Major bone graft (add on) for use with procedure codes that don't already include bone graft For bone harvested from the iliac crest.	$1,085.52
ORAMINB	Minor bone graft (add on) for use with procedure codes that don't already include bone graft For bone harvested from a site other than the operation site or the iliac crest.	$630.08
OTY02	Cauterisation +/- Ablation Mucosa of Turbinates (not to be used in combination)	$3,907.63
OTY08	Tympanostomy/Myringotomy	$2,372.41
OTY09	Myringoplasty - simple +/- patch	$3,911.02
OTY10	Myringoplasty - Endaural/Transcanal/Postauricular	$6,635.02
OTY100	Closed reduction of Fractured Nose – Simple – closed reduction only	$2,761.95
OTY101	Closed reduction of Fractured Nose – Complex - with septoplasty/ Open reduction	$5,660.56
OTY103	Septoplasty – Primary or Revision: - Including cartilage harvested from the operative site	$5,996.66
OTY104	Endonasal Septorhinoplasty – Primary or Revision - Including cartilage harvested from the operative site	$7,929.07
OTY105	External Approach Septoplasty OR Septorhinoplasty – Primary or Revision: - Including cartilage harvested from the operative site	$10,531.47
OTY106	Endonasal Septorhinoplasty Primary or Revision: - Includes minor cartilage graft, temporalis fascia or similar Not for cartilage harvested from the operative site	$10,838.74
OTY107	External Approach Septoplasty OR Septorhinoplasty - Includes minor cartilage graft, temporalis fascia or similar Not for cartilage harvested from the operative sited	$11,209.21
OTY108	Endonasal Septorhinoplasty Primary or Revision with a major graft: - Bone graft – (major) - Autograft (Costal cartilage or Calvarial bone or similar)	$13,973.81
OTY109	Septorhinoplasty External Approach with a major graft – Primary Or Revision: - Bone graft – (major) - Autograft (Costal cartilage or Calvarial bone or similar)	$16,272.21
OTY11	Tympanoplasty - Ossicular Reconstruction +/- prosthesis	$7,825.95
OTY120	Unilateral mini endoscopic sinus surgery (ESS)	$5,496.43
OTY121	Unilateral comprehensive endoscopic sinus surgery (ESS)	$7,071.67
OTY122	Bilateral mini endoscopic sinus surgery (ESS)	$6,441.57

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
OTY123	Bilateral comprehensive endoscopic sinus surgery (ESS)	$8,961.94
OTYATURB	Endoscopic Powered Inferior Turbinoplasties. Add on to be used in conjunction with OTY103 - OTY109.	$1,034.13
SHU01	MUA Shoulder Joint +/- injection NOT TO BE USED IN COMBINATION WITH OTHER CODES NOT TO BE USED AS AN EQUIVALENT	$2,675.49
SHU06	Excision Outer End of Clavicle (not to be used in combination with other codes)	$5,340.77
SHU07	ORIF Clavicle	$6,959.26
SHU08	Open Reduction of AC Dislocation	$7,751.33
SHU09	Proximal Biceps Tendon Tenotomy/Tenolysis/Release. (not to be used in combination with other codes)	$6,672.05
SHU13	Partial Shoulder Replacement	$11,901.67
SHU14	Total Shoulder Replacement	$14,875.48
SHU15	Arthrodesis Shoulder	$9,214.42
SHU16	ORIF Humeral Fracture	$7,817.13
SHU17A	Reverse Total Shoulder Replacement	$14,875.48
SHU20	Removal of plate and screws Humerus. Includes: any excision/revision of initial scar including hypertrophic or keloid scarring	$5,326.88
SHU21	Removal Intramedullary Humeral Rod. Includes: Removal of all locking screws at time of procedure; excision/revision of initial scar	$6,839.92
SHU22	Removal Intramedullary Humeral Rod Locking Screws x 1-3 Includes: excision/revision of initial scar. (Not to be used in combination with Removal of Intramedullary Humeral Rod)	$4,160.79
SHU23	Removal of plate and screws Clavicle. Includes: any excision/revision of initial scar including hypertrophic or keloid scarring.	$4,715.65
SHU50	Shoulder Arthroscopic Surgery - Simple	$6,653.12
SHU51	Shoulder Arthroscopy Proceed to Open Surgery - Simple	$5,537.95
SHU52	Shoulder Open Surgery - Simple	$5,034.52
SHU60	Shoulder Arthroscopic Surgery - Complex 1	$7,039.62
SHU61	Shoulder Arthroscopy - Proceed to Open Surgery - Complex 1	$6,712.80

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
SHU62	Shoulder Open Surgery - Complex 1	$6,041.41
SHU70	Shoulder Arthroscopic Surgery - Complex 2	$8,139.86
SHU71	Shoulder Arthroscopy Proceed to Open Surgery - Complex 2	$8,717.94
SHU72	Shoulder Open Surgery - Complex - 2	$7,719.72
SHU80	Shoulder Arthroscopic Repair - 1 (if majority of procedure is arthroscopic then SHU80 applies) Includes: Any combination of procedures listed under SHU70 AND: Single Tendon rotator cuff repair or Biceps Tenodesis * * Note: Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	$12,246.23
SHU81	Shoulder Arthroscopy and Proceed to Open Repair 1 Includes: Any combination of procedures listed under SHU71 AND: Single Tendon rotator cuff repair or Biceps Tenodesis * * Note: Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	$11,869.46
SHU82	Shoulder Open Repair 1 Includes: Any combination of procedures listed under SHU72 AND: Single Tendon rotator cuff repair or Biceps Tenodesis * * Note: Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	$10,250.78
SHU85	Shoulder Instability Repair – Simple Arthroscopic and/or Open Includes: Any procedure listed in SHU70; SHU71; SHU72 and capsular shift AND:	$12,246.23

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	Repair of Recurrent Dislocation Shoulder Single labral region: Anterior including inferior or; Posterior including inferior OR Repair of SLAP lesion and/or labral tear Single labral region: Superior including posterosuperior and anterosuperior.	
SHU90	Shoulder Arthroscopic Repair 2 (if majority of procedure is arthroscopic then SHU90 applies) Rotator Cuff Repair two or more tendons (one of which may include tenodesis of the Biceps tendon) Includes: Any combination of procedures listed under SHU70 AND: Rotator Cuff repair two or more tendons and may include Biceps Tenodesis * * Note: Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	$15,115.67
SHU91	Shoulder Arthroscopy and Proceed to Open Repair 2 Rotator Cuff Repair two or more tendons (one of which may include tenodesis of the Biceps tendon) Includes: Any combination of procedures listed under SHU71 AND: Rotator Cuff repair two or more tendons and may include Biceps Tenodesis * * Note: Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	$12,255.92
SHU92	Shoulder Open Repair 2 Rotator Cuff Repair two or more tendons (one of which may include tenodesis of the Biceps tendon) Includes: Any combination of procedures listed under SHU72 AND: Rotator Cuff repair two or more tendons and may include Biceps Tenodesis*	$12,300.96

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	* Note: Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	
SHU95	Shoulder Instability Repair – Complex 1 Includes: Any combination of procedures listed under SHU85 and rotator cuff repair one or more tendons (one of which may include tenodesis of the biceps tendon) AND/OR: Repair of extensive labral tear – More than one region and/or Revision Repair of Recurrent Dislocation Shoulder and/or Labral repair and Remplissage of Hill Sachs defect *Remplissage is defined as a posterior capsulotenodesis into a Hill Sach's lesion	$15,115.67
SHU96A	Shoulder Instability Repair – Complex 2: Latarjet Procedure Includes: Osteotomy, transfer and fixation of the coracoid process and attachments and/or other bone graft to glenoid) NOT TO BE USED IN COMBINATION WITH OTHER CODES. NOT TO BE USED AS AN EQUIVALENT	$15,115.67
SKP01	Removal of foreign body	$3,752.00
SKP02	Debridement of skin and subcutaneous tissue	$4,612.61
SKP03	Debridement of skin-partial thickness	$4,307.49
SKP04	Revision of Scar of Face	$4,055.85
SKP05	Revision of Scars of Face (2-4 scars)	$5,066.57
SKP06	Revision of Scar Trunk/limbs	$4,517.21
SKP07	Revision of Scars Trunk/Limbs (2-4 scars)	$5,452.87
SKP09	Split skin graft face and /or neck	$6,245.13
SKP10	Split skin graft trunk and/or limbs	$5,517.75
SKP11	Full thickness skin graft, <20cm	$5,354.67
SKP12	Insertion of tissue expander	$7,869.42
SKP13	Removal of tissue expander(s) and reconstruction	$8,592.44
SKP14	Minor finger surgery (stump revision/cyst)	$2,797.82
SKP15	Excision of Nail and Nail bed (Toe)	$3,073.84
SPN300	Occipito -cervical fusion with instrumentation, any levels. +/- decompression. Includes bone graft	$25,378.98

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
SPN301	Posterior Fusion - C1/2 with instrumentation. Includes bone graft	$20,841.79
SPN302	Posterior C1/2 to cervical fusion with instrumentation, any levels. +/- decompression. Includes bone graft	$25,378.98
SPN303	Posterior Cervical Fusion - Simple – Single Level with instrumentation (excludes C1/2 with instrumentation). Includes bone graft	$13,464.24
SPN304	Posterior Cervical Fusion Complex – Single Level with instrumentation. Includes: Discectomy and/or Decompression and Posterior Laminectomy or Foraminotomy. Includes bone graft	$18,793.60
SPN305	Posterior Cervical Fusion - Simple – Two Levels with instrumentation. Includes bone graft	$19,503.88
SPN306	Posterior Cervical Fusion Complex – Two Levels with instrumentation. Includes: Discectomy and/or Decompression and Posterior Laminectomy or Foraminotomy. Includes bone graft	$23,392.90
SPN307	Posterior Cervical Fusion - Simple – Three or more Levels with instrumentation. Includes bone graft	$22,898.38
SPN308	Posterior Cervical Fusion Complex – Three or more Levels with instrumentation. Includes: Discectomy and/or Decompression and Posterior Laminectomy or Foraminotomy. Includes bone graft	$25,491.05
SPN309	Cervical Laminoplasty 1-2 Levels	$17,345.73
SPN310	Cervical Laminoplasty Complex 1-2 Levels. Includes Decompression (Foraminotomies)	$18,642.07
SPN311	Cervical Laminoplasty 3 or more Levels	$21,388.39
SPN312	Cervical Laminoplasty Complex 3 or more Levels. Includes Decompression (Foraminotomies)	$23,332.90
SPN313	Posterior Cervical Decompression Simple 1 Level	$13,737.17
SPN314	Posterior Cervical Decompression Complex 1 Level. Includes Posterior Discectomy	$15,033.51
SPN315	Posterior Cervical Decompression Simple 2 Levels bilateral	$17,089.78
SPN316	Posterior Cervical Decompression Complex 2 Levels bilateral. Includes Posterior Discectomy	$18,386.11

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
SPN317	Posterior Cervical Decompression Simple 3 Levels or more bilateral	$19,836.09
SPN318	Posterior Cervical Decompression Complex 3 Levels or more bilateral. Includes Posterior Discectomy	$23,139.05
SPN319	Anterior Cervical Discectomy with Fusion 1 Level. No instrumentation. Includes bone graft	$14,972.70
SPN320	Anterior Cervical Discectomy with Fusion - Two or more levels. No instrumentation. Includes bone graft	$17,500.56
SPN321	Anterior Cervical Discectomy and Instrumented Fusion with Graft - Single level. Includes: Discectomy and/or Decompression. Includes bone graft	$15,550.06
SPN322	Anterior Cervical Discectomy Fusion with Instrumentation – One Level. Includes Removal of adjacent segment (s) plate. Includes bone graft	$19,763.17
SPN323	Anterior Cervical Discectomy Revision with Instrumentation - One Level. Includes Removal of Plate or Disc prosthesis. Includes bone graft	$19,763.17
SPN324	Anterior Cervical Discectomy Fusion with Instrumentation – Two or more levels. Includes bone graft	$21,429.63
SPN325	Anterior Cervical Discectomy Fusion with Instrumentation – Two or more levels. Includes Removal of adjacent segment (s) plate. Includes bone graft	$24,022.31
SPN326	Anterior Cervical Discectomy Revision with Instrumentation - Two or more levels. Includes Removal of Plate or Disc prosthesis. Includes bone graft	$24,022.31
SPN327	Cervical Disc Replacement (Arthroplasty) – Single Level. Includes: Discectomy and/or Decompression	$16,779.17
SPN328	Cervical Disc Replacement (Arthroplasty) - Two or more Levels. Includes: Discectomy and/or Decompression	$19,168.10
SPN329	Cervical Hybrid Disc Replacement (Arthroplasty) - Two or more Levels. A single level anterior cervical intervertebral fusion in combination with a single level disc replacement.	$20,253.61

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	Includes: Discectomy and/or Decompression. Includes bone graft	
SPN330	Posterior Thoracic/Thoracolumbar Fusion with instrumentation – Simple. 1 Level (3 segments). Includes bone graft	$22,792.20
SPN331	Posterior Thoracic/Thoracolumbar Fusion with instrumentation – Complex. 1 Level. Includes: Discectomy and/or Decompression. Includes bone graft	$28,301.65
SPN332	Posterior Thoracic/Thoracolumbar Fusion with instrumentation – Simple. 2 Levels (5 segments). Includes bone graft	$25,538.52
SPN333	Posterior Thoracic/Thoracolumbar Fusion with instrumentation – Complex. 2 Levels. Includes: Discectomy and/or Decompression. Includes bone graft	$29,427.54
SPN334	Posterior Thoracic/Thoracolumbar Fusion with instrumentation – Simple. 3 Levels (7 - 12 segments). Includes bone graft	$30,291.46
SPN335	Posterior Thoracic/Thoracolumbar Fusion with instrumentation – Complex. 3 Levels. Includes: Discectomy and/or Decompression. Includes bone graft	$30,553.43
SPN340	Posterolateral Lumbar Fusion Without Instrumentation Simple – Single Level. Includes bone graft	$10,945.66
SPN341	Posterolateral Lumbar Fusion Without Instrumentation Complex - Single Level. Includes: Discectomy and/or Decompression (Including Laminectomy). Includes bone graft	$17,052.06
SPN342	Posterolateral Lumbar Fusion Without Instrumentation Simple – Two or more levels. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used. Includes bone graft	$17,529.78
SPN343	Posterolateral –Lumbar Fusion, without instrumentation Complex – Two or more levels. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used. Includes: Discectomy and/or Decompression. Includes bone graft	$18,177.95
SPN344	Posterolateral Lumbar Fusion with instrumentation Simple – Single level. Includes bone graft	$18,730.68

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
SPN345	Posterolateral Lumbar Fusion with instrumentation Complex - Single level. Includes: Discectomy and/or Decompression. Includes bone graft	$22,652.83
SPN346	Revision Posterolateral Lumbar Fusion with Instrumentation – Single Level. Includes removal implants same level. Includes bone graft	$22,976.91
SPN347	Revision Posterolateral Lumbar Fusion with Instrumentation – Single Level. Includes removal implants at another level. Includes bone graft	$22,976.91
SPN348	Revision Posterolateral Lumbar Fusion with Instrumentation - Single Level. Includes removal implants same level. Includes Discectomy and/or decompression. Includes bone graft	$26,957.00
SPN349	Posterolateral Lumbar Fusion with instrumentation Simple - Two or more levels. Includes bone graft. If the procedure involves more than two levels or the procedure is more complex, non-core pricing can be used.	$20,828.83
SPN350	Posterolateral Lumbar Fusion with instrumentation Complex – Two or more levels. Includes: Discectomy and/or Decompression. Includes bone graft. If the procedure involves more than two levels or the procedure is more complex, non-core pricing can be used.	$26,047.32
SPN351	Revision Posterolateral Lumbar Fusion with instrumentation Simple - Two or more levels. Includes removal implants same level. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$27,190.22
SPN352	Revision Posterolateral Lumbar Fusion with instrumentation Simple - Two or more levels. Includes removal implants another level. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$27,190.22

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
SPN353	Revision Posterolateral Lumbar Fusion with Instrumentation Complex - Two or More Levels. Includes removal implants same level. Includes Discectomy and/or decompression. Includes bone graft. If the procedure involves more than two levels or the procedure is more complex, non-core pricing can be used.	$34,312.44
SPN354	Revision Posterolateral Lumbar Fusion with Instrumentation Complex - Two or More Levels. Includes removal implants another level. Includes Discectomy and/or decompression. Includes bone graft. If the procedure involves more than two levels or the procedure is more complex, non-core pricing can be used.	$34,312.44
SPN355	Single Level Transforaminal Lumbar Interbody Fusion (TLIF) single interbody cage. Includes posterior lateral fusion (PLF). Includes bone graft	$26,388.21
SPN356	Single Level Transforaminal Lumbar Interbody Fusion (TLIF) double cage. Includes posterior lateral fusion (PLF). Includes bone graft	$28,332.72
SPN357	Double Level Transforaminal Lumbar Interbody Fusion (TLIF) single cage. Includes posterior lateral fusion (PLF). Includes bone graft	$30,277.23
SPN358	Double Level Transforaminal Lumbar Interbody Fusion (TLIF) with double cages. Includes posterior lateral fusion (PLF). Includes bone graft	$32,221.74
SPN360	Anterior Lumbar Fusion Simple – Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or. Direct lateral interbody fusion (DLIF). Includes: Discectomy and/or Decompression. Includes Access Surgeon. Includes bone graft. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.	$28,020.21
SPN361	Anterior Lumbar Fusion Simple – Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or. Direct lateral interbody fusion (DLIF). Includes: Discectomy and/or Decompression.	$21,851.02

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	No Access Surgeon. Includes bone graft. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.	
SPN362	Anterior and Posterior Lumbar Fusion Complex - Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). And Posterolateral Lumbar Fusion with or without instrumentation. Includes Access Surgeon. Includes: Discectomy and/or Decompression. Includes bone graft. Not to be used in combination. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.	$33,820.32
SPN363	Anterior and Posterior Lumbar Fusion Complex - Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). And Posterolateral Lumbar Fusion with or without instrumentation. Includes bone graft. No Access Surgeon. Includes: Discectomy and/or Decompression. Not to be used in combination. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.	$27,651.13
SPN364	Revision Anterior Lumbar Fusion - Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). Includes removal implants same level. Includes Access Surgeon. Includes: Discectomy and/or Decompression. Includes bone graft. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.	$30,002.01
SPN365	Revision Anterior Lumbar Fusion - Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). Includes removal implants same level. No Access Surgeon. Includes: Discectomy and/or Decompression. Includes bone graft. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.	$23,147.36

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
SPN366	Anterior Lumbar Fusion Simple - Two or more levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). Includes Access Surgeon. Includes: Discectomy and/or Decompression. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core	$34,119.26
SPN367	Anterior Lumbar Fusion Simple - Two or more levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). No Access Surgeon. Includes: Discectomy and/or Decompression. Includes bone graft. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$25,893.68
SPN368	Anterior and Posterior Lumbar Fusion Complex - Two or More Levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). And Posterolateral Lumbar Fusion with or without instrumentation. Includes Access Surgeon. Includes bone graft. Includes: Discectomy and/or Decompression Not to be used in combination.. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$38,622.83
SPN369	Anterior and Posterior Lumbar Fusion Complex - Two or More Levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). And Posterolateral Lumbar Fusion with or without instrumentation. No Access Surgeon. Includes bone graft. Includes: Discectomy and/or Decompression Not to be used in combination. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$30,397.25
SPN370	Revision Anterior Lumbar Fusion -Two or more Levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF).	$46,010.10

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	Includes removal implants same level. Includes Access Surgeon. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	
SPN371	Revision Anterior Lumbar Fusion -Two or more Levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). Includes removal implants same level. No Access Surgeon. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$33,671.73
SPN372	Lumbar Disc Replacement (Arthroplasty) – Single Level. Includes Access Surgeon. Includes: Discectomy and/or Decompression	$28,077.57
SPN373	Lumbar Disc Replacement (Arthroplasty) – Single Level. No Access Surgeon. Includes: Discectomy and/or Decompression	$21,908.40
SPN374	Lumbar Disc Replacement (Arthroplasty) Two or more levels. Includes Access Surgeon. Includes: Discectomy and/or Decompression; If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$33,033.74
SPN375	Lumbar Hybrid Disc Replacement (Arthroplasty) Two or more levels. Includes a single level anterior lumbar intervertebral fusion in combination with a single level disc replacement. Includes Access Surgeon. Includes: Discectomy and/or Decompression; Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$34,119.26
SPN376	Lumbar Disc Replacement (Arthroplasty) Two or more levels. No Access Surgeon. Includes: Discectomy and/or Decompression; Includes Hybrid operation (a single level anterior lumbar intervertebral fusion in combination with a single level disc replacement).	$25,893.68

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	
SPN380	Lumbar Discectomy Simple – Single level	$10,593.89
SPN381	Lumbar Discectomy Complex – Single level. Includes: extensive foraminal and/or extraforaminal and/or far lateral disc protrusions/extrusions and central disc protrusions/extrusions requiring bilateral approach.	$12,455.27
SPN382	Lumbar Discectomy Simple - Two or more Levels. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$13,548.02
SPN383	Lumbar Discectomy Complex - Two or More Levels. Includes: Extensive foraminal and/or extraforaminal and/or far lateral disc protrusions/extrusions and/or central disc protrusions/extrusions requiring bilateral approach. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$14,844.35
SPN384	Revision Lumbar Discectomy – Single level	$11,402.68
SPN385	Revision Lumbar Discectomy – Two or More Levels. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$13,236.74
SPN386	Spinal Stenosis Decompression - Single level. Includes: Discectomy, Revision discectomy	$13,146.94
SPN387	Spinal Stenosis Decompression - Two or more levels. Includes: Discectomy, Revision discectomy. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$15,219.75
SPN388	Revision Spinal Stenosis Decompression - Single Level. Includes: Discectomy, Revision discectomy	$14,281.04
SPN389	Revision Spinal Stenosis Decompression - Two or more levels. Includes: Discectomy, Revision discectomy. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$17,150.77
SPN390	Coccygectomy	$11,991.39
SPN391	Removal of Spinal Instrumentation (Posterior only). Not to be used in combination (See Revision codes)	$11,807.10
SPN392	Removal Spinal Instrumentation Anterior only. Not to be used in combination (See Revision codes)	$16,406.41
URABASKT	Urology baskets	Actual Costs

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
URABOTOX	Urology botox and botox needle	Actual and Reasonable Cost
URADILAT	Urology dilator	Actual and Reasonable Cost
URAGRASP	Urology grasping and Biopsy forceps	Actual Costs
URAGWIRE	Urology guidewires	Actual and Reasonable Cost
URALASER	Urology Laser Charges (including Hire)	Actual and Reasonable Cost
URASTENT	Urology Stents and ureteric catheters	Actual and Reasonable Cost
URL01	Cystoscopy and urethral dilatation (inclusive of urethroscopy) *Extra costs via Urology add-on codes list above	$4,401.72
URL02	Endoscopic urethrotomy (inclusive of cystoscopy and urethroscopy; visual/optical) *Extra costs via Urology add-on codes list above	$4,862.07
URL03	Cystoscopy (diagnostic/check cystoscopy without any additional procedure) *Extra costs via Urology add-on codes list above	$4,089.53
URL04	Cystoscopy And Injections of botox Injections of bulking agents *Extra costs via Urology add-on codes list above	$5,090.92
URL05	Cystoscopy and bladder biopsy *Extra costs via Urology add-on codes list above	$5,090.92
URL06	Cystoscopy and bladder washout *Extra costs via Urology add-on codes list above	$5,090.92
URL07	Cystoscopy and hydrodistension *Extra costs via Urology add-on codes list above	$5,090.92
URL08	Cystoscopy and retrograde pyelogram *Extra costs via Urology add-on codes list above	$5,090.92
URL09	Cystoscopy and bladder stone removal (with or without laser) *Extra costs via Urology add-on codes list above	$7,971.64
URL10	Cystoscopy and sphincterotomy (with or without laser)	$7,971.64

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
	*Extra costs via Urology add-on codes list above	
URL11	Cystoscopy and Stent Insertion (unilateral procedure) *Extra costs via Urology add-on codes list above	$5,090.92
URL12	Cystoscopy and Stent Insertion (bilateral procedure) *Extra costs via Urology add-on codes list above	$6,004.01
URL13	Cystoscopy and Removal of Stent (unilateral procedure) *Extra costs via Urology add-on codes list above	$5,090.92
URL14	Cystoscopy and Removal of Stent (bilateral procedure) *Extra costs via Urology add-on codes list above	$6,004.01
URL15	Ureteroscopy and/or laser and/or basketing of stones (not meeting criteria for complex stones) – Unilateral *Extra costs via Urology add-on codes list above	$9,992.63
URL16	Ureteroscopy and/or laser and/or basketing of stones (complex stones: renal stones > 10 mm or ureteric stones > 7 mm or > 3 stones or BMI > 30) - Unilateral *Extra costs via Urology add-on codes list above	$12,453.21
URL17	Ureteroscopy and/or laser and/or basketing of stones (not meeting criteria for complex stones) – Bilateral *Extra costs via Urology add-on codes list above	$12,136.00
URL18	Ureteroscopy and/or laser and/or basketing of stones (complex stones: renal stones > 10 mm or ureteric stones > 7 mm or > 3 stones or BMI > 30) – Bilateral *Extra costs via Urology add-on codes list above	$15,625.31
URL19	Insertion of Artificial Urinary Sphincter. Includes activation fee. (First procedure, without history of radiation or urethral surgery). *Extra costs via Urology add-on codes list above	$11,738.70
URL20	Insertion of Artificial Urinary Sphincter. Includes activation fee. (first procedure with history of radiation or history of previous urethral surgery) *Extra costs via Urology add-on codes list above	$16,788.36
URL21	Insertion of Artificial Urinary Sphincter. Includes activation fee. (Revision procedure, includes: partial or total removal of device, partial or total replacement, addition of tandem sphincter cuff).	$16,788.36
URL22	Urethroplasty - with and without graft and harvesting. Operation is performed as an assisted procedure. Additional time for a second surgeon can be invoiced using the ESR09 code. *Extra costs via Urology add-on codes list above	$13,150.81
URL23	Urethroplasty - with and without graft and harvesting. Operation is performed by a single surgeon only. *Extra costs via Urology add-on codes list above	$16,005.68

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
URL24	Urethroplasty (revision) - with and without graft and harvesting. Operation is performed as an assisted procedure. Additional time for a second surgeon can be invoiced using the ESR09 code. To be used where there has been a previous urethroplasty. *Extra costs via Urology add-on codes list above	$15,677.35
URL25	Urethroplasty (revision) - with and without graft and harvesting. Operation is performed by a single surgeon only. To be used where there has been a previous urethroplasty. *Extra costs via Urology add-on codes list above	$19,378.18
URL26	Suprapubic catheter insertion (inclusive of cystoscopy if performed) *Extra costs via Urology add-on codes list above	$4,644.63
URL27	Bladder neck incision *Extra costs via Urology add-on codes list above	$6,300.80
URL28	TUR bladder neck contracture *Extra costs via Urology add-on codes list above	$7,518.26
URL29	Vesico-vaginal fistula repair (vaginal approach) *Extra costs via Urology add-on codes list above	$19,301.94
URL30	Vesico-vaginal fistula repair (abdominal approach) *Extra costs via Urology add-on codes list above	$24,377.30
URL31	Urethral synthetic sling for urinary incontinence Can include any of the following: Revision surgery of male synthetic sling Removal of male synthetic sling Revision of female sling via vaginal approach **only** including: • Removal of female synthetic sling • Partial excision of TVT sling • Transvaginal urethrolysis of synthetic sling *Extra costs via Urology add-on codes list above	$8,522.30
URL32	Urethral autologous sling for urinary incontinence Transvaginal urethrolysis of autologous sling Urethral autologous sling for urinary incontinence Can include any of the following: Revision surgery of synthetic or autologous slings via an abdominal approach (or abdominal **and** vaginal), including: • Partial excision of TVT sling • Removal of female synthetic sling *Extra costs via Urology add-on codes list above	$10,348.49

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
URL33	Can include any of the following: Frenuloplasty Circumcision	$4,566.01
URL34	Penile plication surgery for penile trauma	$6,989.99
URL35	Hydrocele repair (including redo) and evacuation of haematoma	$8,233.74
WAH100	Closed reduction and k-wiring of phalangeal and metacarpal fractures	$5,814.10
WAH101	Open Reduction Internal Fixation (ORIF) phalangeal fracture - Simple Includes: - simple shaft fractures • if 2 digits, each attract a separate code • if > 2 digits then this becomes a noncore procedure	$7,704.35
WAH102	Open Reduction Internal Fixation (ORIF) phalangeal fracture – Complex Includes: - intra-articular fractures, complex comminuted shaft fractures, pilon fractures • if 2 digits, each attract a separate code • if > 2 digits then this becomes a noncore procedure	$9,279.59
WAH103	Hemi-hamate reconstruction of pilon fracture	$12,509.85
WAH104	Open Reduction Internal Fixation (ORIF) metacarpal – Simple Includes: - simple metacarpal shaft fractures • if 2 digits, each attract a separate code • if > 2 digits then this becomes a noncore procedure	$6,437.63
WAH105	Open Reduction Internal Fixation (ORIF) metacarpal – Complex Includes: - intra-articular fractures and 4th and 5th carpometacarpal fracture dislocation • if 2 digits, each attract a separate code • if > 2 digits then this becomes a noncore procedure	$8,327.91
WAH106	Corrective Osteotomy of phalanx Includes: - internal fixation • if 2 digits, each attract a separate code • if > 2 digits then this becomes a non-core procedure	$8,327.91
WAH107	Corrective osteotomy of metacarpal Includes: - internal fixation	$8,327.91
WAH108	Arthrodesis Interphalangeal (IP) joint Includes: - internal fixation • if 2 digits, each attract a separate code • if > 2 digits then this becomes a non-core procedure	$7,697.80

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
WAH109	Arthrodesis Carpometacarpal (CMC) joint Includes: • internal fixation • bone graft	$10,218.18
WAH110	Arthrodesis Metacarpophalangeal (MCP) joint Includes: • internal fixation • bone graft	$7,382.78
WAH111	Carpometacarpal (CMC) joint arthroplasty – Simple Includes: - trapeziumectomy, debridement of joints, excision of avulsion fragments	$8,334.04
WAH112	Carpometacarpal (CMC) joint arthroplasty – Complex Includes: trapeziumectomy plus ligament reconstruction and tendon interposition (LRTI), implant arthroplasty and beak ligament reconstruction	$10,224.32
WAH113	Metacarpophalangeal (MCP) joint arthroplasty – Simple Includes: - silicone arthroplasty (e.g. Swanson) • if 2 digits, each attract a separate code • if > 2 digits then this becomes a noncore procedure	$8,334.04
WAH114	Metacarpophalangeal (MCP) joint arthroplasty – Complex Includes: - cemented and uncemented 2 component implant • if 2 digits, each attract a separate code • if > 2 digits then this becomes a non-core procedure	$10,224.32
WAH115	Repair collateral ligament MCP joint/ IP joint (Metacarpophalangeal joint/Interphalangeal joint) Includes: - volar plate repair	$6,354.53
WAH116	Reconstruction collateral ligament MCP joint/ IP joint - using tendon graft (Metacarpophalangeal joint/Interphalangeal joint) Includes: - volar plate reconstruction with FDS (flexor digitorum superficialis tendon), volar plate advancement	$6,039.49
WAH117	Simple amputation - Digit • if 2 digits, each attract a separate code • if > 2 digits then this becomes a non-core procedure	$5,492.49
WAH118	Ray Amputation - Digit	$6,437.63
WAH119	Tenolysis flexor tendon – Simple Includes: - A1 pulley release, traction tenolysis, flexor tenotomy • if 2 digits, each attract a separate code • if > 2 digits then this becomes a non-core procedure	$5,094.36

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
WAH120	Tenolysis flexor tendon – Complex Includes: - excision of slip of FDS (flexor digitorum superficialis tendon), tenolysis plus arthrolysis of MCPJ/IPJ (Metacarpophalangeal joint/Interphalangeal joint) • if 2 digits, each attract a separate code • if > 2 digits then this becomes a non-core procedure	$9,820.04
WAH121	Tenolysis extensor tendon – Simple Includes: - release stenosing tenosynovitis (incl. De Quervains), intersection syndrome, extensor tenotomy • if 2 digits, each attract a separate code • if > 2 digits then this becomes a non-core procedure	$4,779.32
WAH122	Tenolysis extensor tendon – Complex Includes: - tenolysis plus arthrolysis MCPJ/IPJ (Metacarpophalangeal joint/Interphalangeal joint) • if 2 digits, each attract a separate code • if > 2 digits then this becomes a non-core procedure	$8,559.87
WAH123	Repair flexor tendon digit or palm • if two tendons, each attract a separate code, • if > 2 then this becomes a non-core procedure	$7,929.77
WAH124	Repair flexor tendon wrist or forearm – proximal to the carpal tunnel • if two tendons, each attract a separate code, • if > 2 then this becomes a non-core procedure	$6,039.49
WAH125	Repair extensor tendon – digit or hand/ wrist or forearm • if two tendons, each attract a separate code, • if > 2 then this becomes a non-core procedure	$6,039.49
WAH126	Reconstruction flexor tendon using primary tendon graft Includes: - harvest of tendon graft • if two tendons, each attract a separate code, • if > 2 then this becomes a non-core procedure Excludes: tendon transfer	$9,189.94
WAH127	Reconstruction flexor tendon - 1st Stage tendon reconstruction Includes: - insertion of spacer/rod • if two tendons, each attract a separate code, • if > 2 then this becomes a non-core procedure Excludes: tendon transfer	$9,189.94

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
WAH128	Reconstruction flexor tendon - 2nd Stage tendon reconstruction Includes: - harvest of tendon graft • if two tendons, each attract a separate code, • if > 2 then this becomes a non-core procedure Excludes: tendon transfer	$11,790.11
WAH129	Reconstruction extensor tendon using primary tendon graft Includes: - harvest of tendon graft • if two tendons, each attract a separate code, • if > 2 then this becomes a non-core procedure Excludes: tendon transfer - Should a Staged procedure be required, this would become noncore	$6,669.58
WAH130	Pulley reconstruction - Includes: required tenolysis, use of local tendon or free tendon graft, extensor retinacular reconstruction i.e. ECU (extensor carpi ulnaris) stabilization • if two tendons, each attract a separate code, • if > 2 then this becomes a non-core procedure	$9,505.01
WAH131	Tendon transfer for tendon rupture - Includes: side to side transfer, end to end transfer, end to side • if two transfers required, each attract a separate code, • if > 2 then this becomes a non-core procedure	$7,929.77
WAH132	Carpal tunnel release – Simple - open surgery Primary	$4,149.21
WAH133	Carpal tunnel release – Complex – Open surgery Includes Revision Deep exploration, Extensive neurolysis and tenolysis, +/- vein conduit wrap, +/- local fat flap	$5,094.36
WAH134	Carpal tunnel release – endoscopic	$5,792.80
WAH135	Open Reduction Internal Fixation (ORIF) scaphoid or other carpal bone (includes Hook of Hamate) Includes: - open or percutaneous screw fixation	$8,649.50
WAH136	Scaphoid or other carpal bone reconstruction – Simple Includes: - bone graft from distal radius and fixation	$8,251.35

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
WAH137	Scaphoid or other carpal bone reconstruction – Complex Using structural bone grafting from iliac crest and fixation. Includes: - bone graft from iliac crest and fixation • if a vascularised bone graft is required, this becomes a noncore procedure	$14,081.77
WAH138	Wrist arthroscopic surgery – Simple Includes: - diagnostic arthroscopy and/or removal of loose bodies, simple debridement of synovitis	$5,792.80
WAH139	Wrist arthroscopy proceed to open surgery – Simple Includes: - diagnostic arthroscopy and/or removal of loose bodies, simple debridement of synovitis	$6,737.93
WAH140	Wrist open surgery – Simple Includes: - removal of loose bodies, simple debridement of synovitis	$5,094.36
WAH141	Wrist arthroscopy - Complex 1 - (Intercarpal ligament injury) Includes: - Percutaneous K wiring of joints for intercarpal ligament injury	$6,737.93
WAH142	Wrist arthroscopy and proceed to open - Complex 1 Includes: - Repair of intercarpal ligament and K-wiring of joints	$10,518.47
WAH143	Wrist arthroscopy and proceed to open – Complex 1 – Includes: - Reconstruction of intercarpal ligament and K-wiring of joints	$12,488.54
WAH144	Wrist Open Surgery – Complex 1 – Repair of intercarpal ligament and K-wiring of joints	$11,455.02
WAH145	Wrist open surgery - Complex 1 - Reconstruction of intercarpal ligament and K-wiring of joints	$10,141.64
WAH146	Wrist arthroscopy and proceed to open - Complex 2 - Arthroscopic and proceed to open Proximal Row Carpectomy (PRC)	$9,579.89
WAH147	Wrist arthroscopy and proceed to open - Complex 2 - Partial wrist fusion and Sauve-Kapandji procedure	$10,840.08
WAH148	Wrist arthroscopy and proceed to open - Complex 2 – Total Wrist Fusion	$14,780.20
WAH149	Wrist open surgery - Complex 2 - Proximal Row Carpectomy (PRC)	$8,649.50
WAH150	Wrist open surgery - Complex 2 - Partial wrist fusion and Sauve-Kapandji procedure	$10,539.77
WAH151	Wrist open surgery - Complex 2 - Total wrist fusion	$12,509.85

Procedure Code	Procedure Description	2024 Pricing (excl. GST)
WAH152	Wrist arthroscopy - Complex 3 TFCC injury (triangular fibrocartilage complex) Includes: - diagnosis and TFCC (triangular fibrocartilage complex) debridement	$6,737.93
WAH153	Wrist arthroscopy - Complex 3 Includes: - diagnosis, debridement & repair of TFCC (triangular fibrocartilage complex) tear	$8,628.19
WAH154	Wrist arthroscopy and proceed to open - Complex 3 Includes: - diagnosis, debridement & open repair of TFCC (triangular fibrocartilage complex) tear	$10,840.08
WAH155	Wrist arthroscopy and proceed to open - Complex 3 - Open TFCC (triangular fibrocartilage complex) reconstruction with tendon graft	$12,810.14
WAH156	Wrist open surgery - Complex 3 - Open TFCC (triangular fibrocartilage complex) repair	$8,881.47
WAH157	Wrist open surgery - Complex 3 - Open TFCC (triangular fibrocartilage complex) reconstruction with tendon graft	$10,141.64
WAH158	Open Reduction Internal Fixation (ORIF) distal radius Includes: - ORIF radial styloid	$10,218.18
WAH159	Corrective osteotomy distal radius Includes: Internal fixation	$10,218.18
WAH160	Styloidectomy distal radius	$6,759.22
WAH161	Open Reduction Internal Fixation (ORIF) ulna Includes: - Open Reduction Internal Fixation (ORIF) shaft - distal and styloid	$8,327.91
WAH162	Corrective osteotomy ulna Includes: • Realignment and shortening • Internal fixation	$8,327.91
WAH163	Styloidectomy ulna	$6,759.22
WAH164	Release of Scar/ Fasciectomy – hand - major	$6,669.58
WAH165	Release of Scar/ Fasciectomy - palm/ finger - minor	$5,094.36
WAH166	Excision Pisiform	$7,067.72
WAH167	Excision Hook of Hamate	$8,012.85
WAH168	Repair Nail Bed	$4,464.27
WAH169	Nailbed (finger) reconstruction – Simple Includes: - excision and partial ablation	$5,094.36
WAH170	Nailbed (finger) reconstruction – Complex Includes: - nailbed grafting locally or from toe	$6,039.49

Table 2: Non-core Service Items and Prices

Non-core Procedure Code	Description	Unit of Measure	2023 Price (excl. GST)
ESRNC	Includes Theatre set up, Base Supplies and Recovery Fee	Flat Fee	$1,443.27
ESR01	Theatre time (up to 120 minutes)	Per minute ≤ 120 minutes	$52.48
ESR02	Theatre time (over 120 minutes)	Per minute > 120 minutes	$55.31
ESR03	Anaesthetist's set up RVU	Per RVU	$77.61
ESR04	Anaesthetic other	Actual Costs	Actual Costs
ESR05	Ward stay	Per day	$813.32
ESR06	High Dependency Unit (HDU)	Per day	$1,722.66
ESR07	Intensive Care Unit (ICU)	Per day	$5,926.07
ESR08	Plain x-rays	Per x-ray (max amount	$227.46
ESR09	2nd surgeon - consultant	Per minute	$29.54
ESR10	2nd surgeon - assistant	Per minute	$3.85
ESR11	Splints/Orthotics	Actual Costs	Actual Costs
ESR12	Unique Supplies (consumables, drugs – extra to base)	Actual Costs less $726.98 included in ESRNC for these costs	Actual Costs less $726.98 included in ESRNC for these costs
ESR13	Unusual/Unspecified costs	Actual Costs	Actual Costs
ESR14	Laparoscopic/Endoscopic supplies	Actual Costs	Actual Costs
ESR16	Day stay only	Per day	$426.03
ESR17	Inpatient allied health	Per visit	$57.03
ESR18	Follow up specialist visits	Per visit	$145.29

Price Review

ACC will review pricing when, at ACC's sole discretion, we consider a review necessary. The factors ACC may take into account during a review include, but are not limited to:

- general inflation
- changes in service component costs
- substantial changes in the market

If ACC finds that the factors we take into account have not had a significant impact on price, the prices will remain unchanged.

If ACC provides a price increase, the Supplier must agree any adjustment in writing. The price increase will take effect from a date specified by ACC.

4. RELATIONSHIP MANAGEMENT

Table 3: Relationship Management

Level	ACC	Supplier
Client	Recovery Team / Recovery Team Member	Individual staff or operational contact
Contract Management	Engagement and Performance Manager	Operational contact / National Manager
Service Management	Portfolio Team or equivalent	National Manager

5. ADDRESSES FOR NOTICES (STANDARD TERMS AND CONDITIONS, CLAUSE 23)

NOTICES FOR ACC TO:

ACC Health Procurement (for deliveries)
Justice Centre
19 Aitken Street
Wellington 6011
ACC Health Procurement (for mail)
P O Box 242
Wellington 6140
Marked: "Attention: Procurement Specialist"
Phone: 0800 400 503
Email: health.procurement@acc.co.nz

NOTICES FOR SUPPLIER TO:

_____
_____
_____ (for deliveries)
_____
_____
_____ (for mail)
_____
_____ _____
Marked: Attention: _____ _____, _____
Phone: _____
Mobile: _____
Email: _____

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B. SERVICE SPECIFICATIONS FOR ELECTIVE SURGERY SERVICES

1. PURPOSE

1.1. ACC wishes to purchase Elective Surgery Services.

1.2. The purpose of the Service is:

1.2.1. To purchase timely, effective elective surgical, perioperative and post-discharge procedures and care for eligible ACC Clients (clients) who have a covered personal injury which requires surgical treatment to meet their rehabilitation outcomes.

1.2.2. The Service consists of a package of care including client liaison, preparation for surgery, delivery of surgical procedures, recovery, discharge and follow-up care for a period from the date of discharge.

1.2.3. The Service is provided on a 'Lead Supplier' model, whereby the Supplier ensures the provision of all services and resources required as part of the Service, through owned, employed, leased, or subcontracted resources.

1.2.4. The Service commences upon receipt by the Supplier of a draft surgical Assessment Report and Treatment Plan (ARTP) from a referring specialist and concludes either at the point an ARTP submitted as a request for approval is declined by ACC or the Client terminates treatment, or (if the ARTP is approved) six weeks from the date of discharge from the Treatment Facility. This period from commencement of Services to conclusion of the Services is the Care Period.

1.2.4.1. If a Procedure is specified in Appendix 4 of the Elective Surgery Operational Guidelines and meets the conditions specified in that Appendix, the Service commences when the Provider notifies the Supplier of the impending procedure.

1.2.5. The Supplier is the accountable party during the Care Period for the delivery of all services to the Client, including non-clinical support services such as organising treatment, treatment preparation advice, recovery support advice and similar activities, which may not be explicit in the codes listed in Part A, but are normally expected as contributing to a high standard of customer service.

2. SERVICE OBJECTIVES

2.1. ACC will measure the success of this Service based on the following objectives:

2.1.1. This Service aims to contribute to optimal treatment and rehabilitation outcomes for the Client.

2.1.2. This service specification covers the purchasing of elective surgical treatment through inpatient and day-patient procedures and outpatient post discharge/post procedure care and includes diagnosis for all clients where this has not been completed earlier.

2.1.3. This service specification outlines the requirements that the Supplier and Named Provider must meet in the specialties included in (but not limited to) the list below:

2.1.3.1. General Surgery;

2.1.3.2. Maxillo-facial;

2.1.3.3. Neurology and neurosurgery;

2.1.3.4. Obstetrics and Gynaecology

2.1.3.5. Ophthalmology;

2.1.3.6. Oral surgery;

2.1.3.7. Orthopaedics;

2.1.3.8. Otorhinolaryngology (ENT)

2.1.3.9. Plastic surgery and;

2.1.3.10. Urology.

3. DEFINITION OF "SERVICES"

3.1. In this Service Schedule, unless the context otherwise requires:

3.2. "Services" includes all and any part of the Treatment and Outpatient Post-Discharge/Post Procedure Care Services described below, and other services described elsewhere in this Service Schedule, to be provided for Clients subject to and in accordance with provisions of this Contract, and includes:

3.2.1. All incidental services which a reasonable and responsible supplier of similar services would provide to meet the physiological, cultural, spiritual and social needs of clients receiving the Services, for example interpreter services

3.2.2. Access for the Client to education (such as but not limited to advisory material) about injury prevention and rehabilitation consistent with the goals and strategic directions of ACC (noting that this Service Schedule only addresses the actual delivery of Elective Surgery Services and that the Supplier is not contracted to provide injury prevention services or rehabilitation services beyond the scope of this Service Schedule).

3.3. Lead Supplier

3.3.1. The Lead Supplier is the organisation with which ACC contracts for the purposes of procuring elective surgery and associated services, and which is accountable for a range of activities (which are elaborated upon in the following clauses of this Service Schedule as indicated) including but not limited to:

3.3.1.1. All invoicing to ACC (as per clauses 31 to 37),

3.3.1.2. All payments to subcontractors, including hospitals, clinicians, allied health or support staff

3.3.1.3. All quality standards required under this contract and/or generally accepted in the New Zealand Health Sector (see clauses 14, 15, 17, 27, 29, 30, 38, or other applicable clauses)

3.3.1.4. All administration required in providing care to the client, including a comprehensive Patient Management System meeting the normally accepted standards of the New Zealand health sector, including the Health Industry Privacy Code of Practice (as per clauses 3, 22, 23, 24, 25, 35, or other applicable clauses)

3.3.1.5. All reporting to ACC or other agencies (as per clauses 30, 31 (and 40 in respect to DHBs) or other applicable clauses)

3.3.1.6. All health and safety obligations under this contract or under legislation (as per our Standard Terms and Conditions

3.3.1.7. All information technology or related system requirements to interface with ACC systems as defined from time to time (as per clause 16, or other applicable clauses)

3.3.1.8. Maintaining and developing professional skills for all clinicians and other staff who either are employed by or subcontract for an annual average of over 20 hours per week to the organisation, to a standard required by professional bodies or which meets the normally accepted standards of the New Zealand health sector (as per clauses 14, 15, 17, 29, 38, or other applicable clauses.

3.4. Package of Care

3.4.1. Those services which are delivered to a Client (including administrative services pursuant to treatment and case reporting as required to ACC) form a 'package of care', which by definition occurs within the Care Period defined in Part B Clause 1.2.4.

3.4.2. The following Services are not purchased under this Service Schedule but may be purchased by ACC under other contracts or under Regulations, if required or as applicable:

3.4.2.1. Public Health Acute Services (PHAS) as defined under the Accident Compensation Act 2001.

3.4.2.2. Client and escort transport and escort accommodation costs as a result of the provision of Assessment or follow-up Treatment;

3.4.2.3. Home-help provision;

3.4.2.4. Attendant Care;

3.4.2.5. Childcare;

3.4.2.6. Outpatient allied health follow-up care (post Discharge Date);

3.4.2.7. Long term Equipment for Independence or Orthotics (i.e. Equipment for Independence or Orthotics which will be required for longer than six weeks post Discharge Date);

3.4.2.8. Prosthetics (e.g. artificial limbs);

3.4.2.9. Diagnostic imaging services required after Discharge Date;

3.4.2.10. Outpatient and community nursing services

3.4.2.11. Replacement of simple dressings or castings post-discharge within the Care Period

3.4.2.12. Inpatient rehabilitation following Treatment, and

3.4.2.13. Pharmaceuticals required after Discharge.

4. SERVICE LOCATIONS

4.1. The Supplier will provide Services only at the locations specified in Part A Clause 2.

5. ELIGIBILITY FOR SERVICE

5.1. A Client is entitled to Services from the Supplier under this Service Schedule if

5.1.1. They have suffered a personal injury as defined in the AC Act;

5.1.2. They have been accepted by ACC as having cover for that injury;

5.1.3. The Supplier has submitted a completed ARTP, unless Part B clause 18.7 applies;

5.1.4. ACC has approved funding for the Treatment, unless Part B clause 18.7 applies; and

5.1.5. All the relevant provisions of this Service Schedule are complied with.

6. SUMMARY OF REFERRAL PROCESS

6.1. Unless Part B clause 18.7 applies, the Supplier will receive a draft ARTP from a referring specialist and is accountable for ensuring the ARTP meets the standards required by ACC. The ARTP form on the ACC Website is the ACC approved version and is the only version of ARTP form that will be accepted by ACC. (This clause will also cover any subsequent automation of the ARTP process).

6.2. The Supplier will ensure they are able to meet the Clinical Priority timeframe requirement for each Client, including ensuring that they have sufficient capacity in and theatre (see Part B clause 22.7 for process to be followed if the Supplier cannot ensure this).

6.3. Unless Part B clause 18.7 applies the Supplier will follow the applicable funding approval process set out at Part B clauses 18 (excluding Part B clause 18.7) to 21.

6.4. Unless Part B clause 18.7 applies, ACC will process the application and advise the Client and the Supplier simultaneously in writing whether ACC approves or declines funding for the recommended Treatment. If approved, ACC will advise the Supplier of the Purchase Order Number and any change in the Priority Category for the Treatment.

6.5. If Part B clause 18.7 applies, the Supplier may procced with the Treatment without approval from ACC and invoice ACC without a Purchase Order Number.

7. CONTENT REQUIREMENTS FOR AN ARTP

7.1. The Supplier will ensure that an ARTP clearly identifies the procedure the Client will undergo using the codes in Part A of this Service Schedule, and any additional requirements beyond those considered standard for the procedure and Client involved, including (but not limited to) unusual rehabilitation equipment, anticipated follow-up procedures (for instance for the removal of metalware) or non-standard pharmaceuticals.

7.2. The Supplier will ensure that an ARTP adequately identifies the reasonable clinical prognosis for the Client, including estimated return to independence and/or work durations, and any reasonably-anticipated follow-up care, including:

7.2.1. The further treatment or support which will be necessary as a component of rehabilitation

7.2.2. The reasonably-expected timeframe for the client to return to independence (or, in the case of an employed person, a possible staged return to work involving, for instance, light duties)

7.2.3. Any other information reasonably required by ACC, including but not limited to relevant diagnostic imaging or any additional information, including reports, for the purposes of considering the Client's cover and entitlement to ACC funding or for the purposes of invoice processing.

7.2.4. Any other recommendations or comments which might be helpful to the Client and to ACC in optimising the Client's recovery.

7.3. ACC is under no obligation to the Supplier or referring specialist to process an ARTP which does not meet ACC's requirements as set out in this Service Schedule and on the ACC Website.

7.4. If an ARTP does not meet ACC's standards the Supplier will return the ARTP to the relevant Named Provider for the ARTP to be completed.

8. TRANSFER OF LEAD SUPPLIER

8.1. If, after the approval of an ARTP by ACC, or Part B clause 18.7 applies, but before Treatment starts, a Client consents to being transferred from one Supplier to another, both the 'sending' and 'receiving' suppliers will ensure a smooth transfer of care and establish reasonable standards for the supply of medical notes and other appropriate documentation.

8.2. The sending Supplier is responsible for notifying the receiving Supplier that a transfer of Lead Supplier has been made.

8.3. The 'receiving' supplier will assume all supplier responsibilities in respect of the transferred Client's Treatment and service levels described in this Service Schedule from the date the 'sending' Supplier agrees to the transfer.

9. COMMENCEMENT AND ENDING OF SERVICES UNDER THIS SERVICE SCHEDULE

9.1. Unless Part B clause 18.7 applies, the Services that ACC purchases may not commence until ACC has approved funding for the Treatment under clause 18 (excluding Part B clause 18.7) of this Service Schedule.

9.2. The Services end when:

9.2.1. A written Referral of the Client to the original Referrer has been completed following a transfer of clinical responsibility and care; and

9.2.2. Appropriate documentation has been completed (e.g. Referral, Notice of Discharge, Operation Note) and received electronically by ACC.

10. TREATMENT

10.1. Commencement and Ending

10.1.1. Treatment is initiated by:

10.1.1.1. ACC funding approval of an ARTP pursuant to Part B clauses 6, 7 and 18 (excluding Part B clause 18.7) to 21; or

10.1.1.2. if Part B clause 18.7 applies, the Provider notifying the Supplier of the impending procedure.

10.1.2. Treatment ends after Discharge, Referral to Post Discharge/Post Procedure Care or on a Significant Complication Transfer of Care, and when appropriate documentation has been completed and submitted electronically.

10.2. Definition of “Treatment”

10.2.1. Treatment includes, but is not limited to:

10.2.1.1. anaesthetic pre-assessment including completion of a pre-surgical anaesthetic form in accordance with standards required by the Australian and New Zealand College of Anaesthetists and other relevant professional bodies. Where the Client has significant co-morbidities, the Supplier will ensure that the Client is seen under the Clinical Services contract by a vocationally registered Anaesthetist. Where the co-morbidities are identified as requiring services outside the normal services for this type of surgery the Supplier will apply for funding for a Non-Core Procedure in accordance with Part B, clause 18.4;

10.2.1.2. surgical treatment on an inpatient or day patient basis as is appropriate for the type of treatment, and the circumstances of the Client;

10.2.1.3. post procedure care before discharge;

10.2.1.4. delivery of all associated care and treatment by a team of professionals including medical, nursing, physiotherapy, anaesthetist, occupational therapy, social work, technical and (on an inpatient basis only) allied health professionals, as well as Referral to, and assessment by, other types of Suppliers / Providers during the treatment, as required;

10.2.1.5. all consumables, implants, supplies, standard hotel type costs, transfer costs, laboratory (pathology) tests, diagnostic imaging services, pharmaceutical items (including pre-operative pharmaceuticals), and other associated items to perform the treatment;

10.2.1.6. availability and use of a range of equipment appropriate to the specialty, level of service and the treatment being provided;

10.2.1.7. short term Equipment for Independence if required by Clients prior to or on Discharge to achieve a suitable rehabilitation outcome from the treatment, for up to six weeks post-Discharge Date (for example, a shower stool, walking frame, crutches or a wheelchair);

10.2.1.8. any Orthotics (and any associated Orthoses) required by Clients prior to or on Discharge to achieve a suitable rehabilitation outcome from the treatment, for up to six weeks post-Discharge Date (for example, splints, shoulder braces);

10.2.1.9. clinical support services to a level appropriate for the type of treatment to be provided, as outlined in the Guide to Role Delineation of Health Services in New Zealand, Crown Health Enterprise Monitoring Unit (September 1993) or succeeding document; and

10.2.1.10. any administrative matters as would normally be required to allow the Supplier to monitor the outcome of treatment. Recording of service outcomes in clinical notes and/or through internal information systems is required to allow the Supplier or ACC to evaluate the Service.

11. OUTPATIENT POST DISCHARGE / POST PROCEDURE CARE

11.1. Post Discharge/Post Procedure Care for a Client begins following Discharge from a facility where Treatment has been carried out and ends six weeks after discharge.

11.2. On conclusion of Post Discharge/Post Procedure Care, the Supplier will arrange a Referral of the Client from the care of the Supplier back to the Client's original Referrer or (with the Client's consent) to another General Practitioner if appropriate.

11.3. Post Discharge/Post Procedure Care includes but is not limited to:

11.3.1. any necessary and appropriate follow-up and care by the Named Provider, other staff or subcontractors to the Supplier, provided in Named Provider clinics on an Outpatient (but not inpatient or day patient) basis, but excluding services listed under Part B clause 3.4.2;

11.3.2. provision of any short- term equipment for independence from the date of discharge to the conclusion of the Care Period if not already provided in the Treatment phase; and

11.3.3. any Orthotics (and any associated Orthoses) required from the date of discharge to the conclusion of the Care Period.

11.4. The Supplier will also provide the following administrative services required by this Service Schedule:

11.4.1. producing the invoice;

11.4.2. entering National Health Index (NHI) data (if relevant);

11.4.3. arranging further follow up;

11.4.4. monitoring outcomes and recording of Service outcomes in clinical notes and/or through internal information systems to allow the Supplier or ACC to evaluate the Service;

11.4.5. any other administrative requirements reasonably required by ACC from time to time.

11.5. On expiry of the Care Period the Supplier will arrange a Referral of the Client from the care of the Named Provider back to the Client's original Referrer or General Practitioner (whichever is appropriate).

11.6. Where the Named Provider identifies that a Client will require inpatient rehabilitation following Treatment, the Supplier will advise the appropriate DHB prior to the transfer and arrange for such inpatient rehabilitation to be provided by the DHB nearest to the Client's home. (Note: such inpatient rehabilitation will be provided as a community admission under ACC's contract with DHBs for non-acute inpatient rehabilitation and requires the Rehabilitation supplier to obtain prior approval from ACC).

12. FURTHER PROVIDER LEVEL CARE

12.1. If, at the end of the Care Period, further specialist follow-up care is required, this may be provided only under the Clinical Services contract, or under the applicable regulations.

12.2. A further ARTP and funding approval from ACC will be required before the Supplier may proceed with further Treatment for a Client at the end of the Care Period, unless this requirement had been specified and agreed in the initial ARTP as integral to a staged approach to surgery and treatment as defined in this Service Schedule or Part B clause 18.7 applies.

13. IMPACT ON CLIENTS OF TERMINATION OF SERVICE

13.1. If the term of this Service Schedule is terminated or ends without replacement, or where the Supplier terminates the Term, the following provisions shall apply in respect of Clients whose package of care has commenced:

13.1.1. If a Client has not been admitted prior to the End Date or earlier Termination Date and the Supplier does not enter into a further agreement with ACC that provides for the Treatment of that Client, then the Supplier will immediately refer the Client to another contracted supplier.

13.1.2. Despite any other clause in this Service Schedule, if a Client has not been discharged from Post Discharge / Post Procedure Care prior to the End Date or earlier Termination Date, the Supplier shall continue to provide Treatment and ACC shall pay the Supplier for such Services, as if the Contract had not ended.

14. SERVICE REQUIREMENTS AND RESOURCES

14.1. Clinical Resources

14.1.1. The Supplier must have or ensure the availability of a Vocational Registered Medical Specialist acting in the role of Chief Clinical Officer at the facility where service is being provided, noting that formal titles may differ.

14.2. The Supplier must have or ensure the availability of a multidisciplinary team which includes:

14.2.1. A medical team led by a qualified surgeon, with the appropriate level of training and experience. Ideally two surgeons working closely together should form the core of the surgical team in the specialty to ensure adequate backup and opportunity for peer review;

14.2.2. An Anaesthetist who will ensure that pre-assessments are undertaken on all Clients; and who will make final recommendations on HDU/ICU access for those Clients deemed to need that level of care;

14.2.3. A nursing team led by a registered nurse with specialised surgical experience;

14.2.4. Theatre staff who are sufficiently skilled to provide the necessary assistance during each surgery to maintain safe clinical practice;

14.2.5. Other allied staff including physiotherapists, occupational therapists, social workers and technicians with appropriate specialty experience and qualifications;

14.2.6. Ongoing staff education programmes or access to education programmes aimed at keeping staff up to date with developments in the field as an integral part of the service;

14.2.7. Access to 24-hour emergency cover provided by qualified staff. Procedures must be in place for people re-presenting with complications following day surgery. Clients will be given written instructions and an explanation of how to gain access to after-hours medical attention in the event of complications arising. All Clients who have had day surgery will be contacted within 24 hours of discharge by a member of the day unit staff;

14.2.8. A contingency plan to maintain continuity of Service in the event of temporary or permanent loss to the Supplier of any key personnel.

14.3. Managing Conflicts of Interest

14.3.1. In addition to the obligations of clause 18 of ACC's Standard Terms and Conditions, where the Supplier is fully or partly owned directly or beneficially by a clinician who may be making referrals to the Supplier in the course of treating ACC Clients, you will follow the process in clause 18.2 to satisfy ACC that there are appropriate safeguards in place to ensure that the treatment provided to such Clients is demonstrably appropriate and effective. The parties note that the Medical Council of New Zealand has issued guidance on this matter, available on the Council's website.

14.3.2. The Supplier will provide a list to ACC of its actual or beneficial owners who are clinicians who may refer ACC clients to the Supplier for services and will update that list when necessary during the term of this Service Schedule.

14.4. Organisational Quality Standards

14.5. In addition to the requirements specified in clause 27 of the Standard Terms and Conditions, the Supplier will ensure that each facility listed in Part A clause 2 meets and maintains the following requirements (whether the facility is operated by the Supplier or an approved subcontractor):

14.5.1. Hold current certification with the Ministry of Health under the Health and Disability Services (Safety) Act 2001 (NZS 8134:2021 Ngā paerewa Health and Disability Services Standard); and/or

14.5.2. If not required by the Ministry of Health to hold current certification with the Ministry of Health under the Health and Disability Services (Safety) Act 2001, hold current accreditation with the NZS8164:2005 Standard for Day-stay Surgery and Procedures

14.5.3. Ensure that only Named Providers who are working within their vocational scope of practice, and that hold a current certificate of practice, provide services.

14.5.4. The Supplier will provide ACC, upon request, with evidence that these requirements are met.

14.6. Philosophy

14.7. The following underlying philosophies apply to this service specification:

14.7.1. Package of Care – the Supplier will provide all necessary and appropriate services deemed necessary to carry out the Service as a package of care for the total price set out in this Contract for the applicable Procedure from the time of a Client's first visit to the Supplier's facility through the operative and day stay or inpatient stay until six weeks from that date of discharge.

14.7.2. Customer Service - the Supplier will ensure that the highest standards of customer service prevailing in the health sector generally are provided to all Clients.

14.7.3. Multi-disciplinary Management - the Supplier will have a multidisciplinary team of clinicians who jointly treat and assess Clients.

14.7.4. Minimally Invasive Techniques - ACC encourages the recommendation and use of minimally invasive techniques.

14.7.5. Increase in Day Surgery – ACC supports the trend towards a greater proportion of surgery being undertaken on a day case basis where this is clinically appropriate.

14.7.6. Referrals to and from other Providers – the important role of consultation and access to a second opinion are acknowledged and unnecessary barriers to these should be avoided.

14.7.7. Reduced Length of Stay – ACC supports reduced length of stay. Where appropriate, home care arrangements shall be made available where patient safety is not risked.

15. CREDENTIALING PROGRAMME

15.1. The Supplier will have a credentialing programme acceptable to ACC which:

15.1.1. Must include an organisational Credentialing Policy which is documented and is consistent with the Ministry of Health Credentialing Framework for New Zealand Health Professionals 2010 (or any replacement document).

15.2. The Supplier will provide evidence to ACC of the credentialing programme and the Named Providers who have been credentialed under the credentialing programme when there have been any significant, relevant changes to the credentialed status of a Named Provider, or on request from ACC.

16. ELECTRONIC COMMUNICATION

16.1. All ARTPs, Notices of Discharge, Operation Notes, and Referrals must be sent to ACC electronically, in accordance with any reasonable processes for electronic communication specified by ACC.

17. NAMED PROVIDERS

17.1. All Named Providers and Named Red List Providers must have vocational registration. This may include a provisional scope registration with the Medical Council of New Zealand, where the named provider is acting according to the conditions of that limited scope registration. Registrars cannot, under any circumstances, be Named Providers or Named Red List Providers for the purposes of this Contract. ACC may in its sole discretion accept or decline each such request to accept a proposed Named Provider with or without conditions, by providing written notification to the Supplier.

17.2. The Supplier will utilise the services of only:

17.2.1. the Providers named in Part A clause 3.1 (the “Named Providers”) in the course of providing Services for Clients which are Core Procedures or Non-Core Procedures;

17.2.2. the Providers named in Part A clause 3.2 (the “Named Red List Providers”) in the course of providing Services for Clients which are Red List Procedures.

17.3. Addition of Named Providers

17.3.1. The Supplier may make a written request to ACC for a Provider to be added to the list of Named Providers or the list of Named Red List Providers.

17.3.2. If a request is accepted under this clause, the Provider shall be deemed added to the list of Named Providers or the list of Named Red List Providers, whichever is applicable, from the date of ACC’s written notification to the Supplier.

17.4. Proper Consideration

17.4.1. If the Supplier is approached by a properly qualified Provider seeking the Supplier's support to be included in the list of Named Providers, the Supplier must give reasonable and proper consideration to that request in accordance with the law including, without limitation, the Commerce Act 1986, for instance in respect of taking advantage of market power.

17.5. Removal of Named Providers

17.5.1. Either party may provide written notification to the other party that a Named Provider or a Named Red List Provider is to cease to be a Named Provider or a Named Red List Provider under this Contract. The Provider shall be deemed to cease to be a Named Provider or a Named Red List Provider 5 (five) business days after receipt of the notice. ACC shall not issue such a notice arbitrarily.

17.6. Named Red List Providers

17.6.1. Each Named Red List Provider may only provide Red List services for Clients whose personal injury relates to that Provider's selected sub-speciality or sub-specialities as listed in Part A clause 3.1.

17.6.2. A Provider may only be named as a Red List Provider if the Provider has obtained approval by the New Zealand Orthopaedic Association, on behalf of its various Speciality Societies, or the appropriate professional body for a non-orthopaedic surgeon, and ACC has approved the application in accordance with Part B clause 17.1 above. ACC reserves the right to decline to accept new Named Red List Providers.

17.7. Use of Registrars

17.7.1. Notwithstanding section (a) of this clause, the Supplier may permit a Named Provider to employ or contract a Registrar to provide follow-up consultations after discharge, or to assist in Ward. Such a Registrar will be a trainee in a relevant vocational training programme approved by the Medical Council of New Zealand and by other relevant Colleges or professional bodies for training specialists, and will be working at a level permitted by the training programme under the standards of supervision that training programme requires. The Named Provider will assume full accountability to the Supplier under this contract for the quality of any service provided by a Registrar under this clause.

17.7.2. ACC will not pay for additional surgeon or other resource where a Registrar provides services under clause 17.7.

18. FUNDING APPROVAL

18.1. Process Limited

18.1.1. Unless Part B clause 18.7 applies (where an application is not required for Procedures), an application for funding approval, except for a Treatment Injury Procedure, may be made only for Core Procedures included in Part A clause 4, Red List Procedures included in Appendix 2 of the Elective Surgery Services Operational Guidelines, or for Non-Core procedures in accordance with Part B clause 31.

18.1.2. An application for funding approval for a Treatment Injury Procedure may be made under this Contract only in accordance with Part B clause 32.

18.1.3. Unless Part B clause 18.7 applies, the Supplier will not accept any Referrals that are not approved by ACC in accordance with this Part B clause 18.

18.2. Approval Process

18.2.1. The Supplier will forward the following information to the Treatment Assessment Centre, for all applications for funding approvals under this Part B clause 18:

18.2.1.1. The completed ARTP;

18.2.1.2. The date that the Supplier received the draft ARTP;

18.2.1.3. Contract number of this Service Schedule;

18.2.1.4. Proposed month for the Procedure.

18.2.2. The Supplier will forward this information in electronic format. The list of appropriate electronic addresses is available on the ACC Website.

18.2.3. The Supplier will use the ARTP document available on the ACC Website. This is the only version that will be accepted by ACC.

18.3. Core or Red List Procedure Approval Process

18.3.1. ACC will consider the Client's cover and entitlement upon receipt of an application for funding approval.

18.3.2. ACC will advise the Supplier and Client in writing of its funding decision, and if approved, the approval number and any change in the Priority Category.

18.3.3. Appendix 2 of the Elective Surgery Services Operational Guidelines contains the full list of Red List Procedures; Part A clause 4 includes the agreed prices for these procedures. In addition to the agreed prices, the Supplier may submit a quotation for the price prior to the Procedure or submit an invoice for the Procedure using the codes and descriptions in the Additional Resources list on the ARTP.

18.3.4. Where the main component of a Procedure is equivalent to a Core Procedure but additional service items are required (examples of additional service items may include, but are not limited to, 2nd Surgeon Consultant, extra ward stay, HDU care if deemed clinically appropriate, specialist in-ward follow-up consultations), the Supplier must apply for the approval of the procedure, and then invoice the procedure as a Core Procedure with the additional service items listed as ESR units.

18.3.5. If the Supplier applies for approval of price prior to a Procedure where the main component of a Procedure is equivalent to a Core Procedure, but additional service items are required, the Supplier must provide clinical information with these requests to support costs. ACC may decline an application for approval as a Non-Core Procedure and approve the Procedure as a Core Procedure with additional service items,

18.3.6. If the Supplier submits an invoice for a Procedure as a Non-Core Procedure where the main component of a Procedure is equivalent to a Core Procedure, but additional service items are required, the Supplier must provide clinical information with the invoice to support costs. ACC may decline to pay an invoice for such a Procedure as a Non-Core Procedure and instead approve and pay for the Procedure as a Core Procedure with additional service items,

18.3.7. The Supplier will forward all information to the Treatment Assessment Centre, or such other location advised by ACC.

18.4. Non-Core Procedures

18.4.1. When any Non-Core Procedure is recommended the Supplier will forward the following information to the Treatment Assessment Centre, or such other location advised by ACC, in addition to the information required under Part B clause 18.4:

18.4.2. a completed ARTP ensuring the Non-Core Units pricing sheet is completed with an accurate estimate of potential procedure and implant costs; and

18.4.3. any additional information such as reports reasonably requested by ACC for the purposes of considering the Client's cover and entitlement to ACC funding or for the purposes of invoice processing.

18.4.4. ACC will advise the Supplier and Client in writing of its funding decision, and if approved, the approval number and any change in the Priority Category.

18.5. If Funding Approved

18.5.1. On receiving ACC's advice that funding has been approved, the Supplier will promptly contact the Client to arrange a mutually appropriate date for Admission or attendance for Treatment. When that date has been agreed, the Supplier will confirm the booking in writing to the Client.

18.5.2. If ACC advises the Supplier that funding has been approved for a Procedure under Part B clause 18.4 and the Supplier and ACC are unable to agree a price for the Procedure; ACC will require the Supplier to Refer the Client to another supplier approved for the purpose by ACC.

18.6. If Funding Declined

18.6.1. If ACC advises the Supplier that funding has been declined the Client will not be eligible for Services, and payment will not be made to the Supplier, under this Contract.

18.7. Procedures that are exempt from the funding process and do not require prior-approval:

18.7.1. Procedures listed in Appendix 4 of the Elective Surgery Operational Guidelines (the "Non-Prior Approval Procedures" list) that meet the corresponding conditions specified in Appendix 4 are exempt from the Funding Approval Process specified in Part B clauses 18.2 to 18.6 above and do not require approval from ACC. Those Procedures may be commenced by the Supplier.

18.7.2. The Non-Prior Approval Procedures list and Part B clause 18.7.1 applies to all Suppliers unless ACC has notified the Supplier otherwise. If a Supplier has been notified by ACC that clause 18.7.1 does not apply to them and they cannot use the Non-Prior Approval Procedures list, they must follow the Funding Approval Process specified in Part B clauses 18.2 to 18.6 for all Procedures.

18.7.3. ACC reserves the right to amend the Non-Prior Approval Procedures list at any time and will provide reasonable notice to the Supplier of the changes to the list.

19. FUNDING FOR TREATMENT INJURY PROCEDURES

19.1. When a Treatment Injury Procedure is recommended the Supplier will forward to the Treatment Assessment Centre or such other location advised by ACC, in addition to the information required under Part B clause 18.2:

19.1.1. information as is required in accordance with Part B clauses 18.3 to 18.4 (whichever category the proposed Treatment Injury Procedure falls into);

19.1.2. Notification that the Procedure for which funding approval is sought is a Treatment Injury Procedure.

19.2. On receipt of an application for funding approval for a Treatment Injury Procedure ACC will process the application in accordance with Part B clause 18.3 to 18.4 (whichever category the proposed Treatment Injury Procedure falls into);

19.3. If ACC approves the application the Supplier will receive confirmation from ACC that ACC will pay the price approved or agreed with the Supplier in accordance with Part B clause 18.3 to 18.4 (whichever category the proposed Treatment Injury Procedures falls into) if cover is subsequently granted to the Client in respect of the injury which is the subject of the Treatment Injury Procedure.

19.4. To avoid doubt, this clause 19 does not apply to Procedures specified on the Non-Prior Approval Procedures list.

20. RETROSPECTIVE FUNDING APPROVAL FOR ALTERNATIVE UNANTICIPATED TREATMENT OR ALTERNATIVE TREATMENT

20.1. This clause will apply if, on commencing a Procedure approved by ACC under Part B clause 18, a Named Provider concludes, for clinical reasons, that an alternative unanticipated Procedure or an alternative Procedure is necessary and is more appropriate for the treatment of the Client's personal injury for which cover has been accepted by ACC under the AC Act 2001.

20.2. If a Named Provider reaches this conclusion, the alternative unanticipated Procedure or alternative Procedure may be carried out, and the Supplier may forward to ACC a detailed invoice and, other than where Part B clause 18.7 applies for the alternative unanticipated Procedure or an alternative Procedure, application for retrospective funding approval as described in in Part B clauses 20.3 to 20.6 below.

20.3. Application

20.3.1. An application for retrospective funding approval must include:

20.3.2. Name and details, including MBS-E Code (or replacement code), of the alternative unanticipated Procedure or alternative Procedure;

20.3.3. Clinical reasons, and any other reasons, why the alternative unanticipated Procedure or alternative Procedure was necessary and more appropriate;

20.3.4. Any other information ordinarily required from the Supplier to enable ACC to complete the approval process.

20.4. Consideration of Application

20.4.1. ACC will:

20.4.1.1. Consider such an application as if the alternative unanticipated Procedure or alternative Procedure had not yet been carried out, in accordance with all applicable provisions of this Contract;

20.4.1.2. Advise the Supplier in writing of ACC's decision regarding ACC funding for the Treatment. The advice will be deemed to have been received by the Supplier 2 (two) business days after dispatch from ACC by courier or by email to the suppliers stated contact email address on this contract or its normal email address for correspondence with ACC, and will be effective from the date the Procedure was performed.

20.5. Prices

20.5.1. This clause applies if ACC approves the unanticipated Procedure.

20.5.2. If the alternative unanticipated Procedure or alternative Procedure is listed in Part A clause 4 ACC will pay the price provided for that Procedure in Part A clause 4.

20.5.3. ACC will pay the Market Price for the Procedure if the alternative unanticipated Procedure or alternative Procedure is:

20.5.3.1. Not listed in Part A clause 4; and

20.5.3.2. Not a Procedure on ACC's Core Procedure List,

20.6. If the alternative unanticipated Procedure or alternative Procedure is:

20.6.1. Not listed in Part A clause 4; and

20.6.2. Not a Procedure on ACC's Core Procedure List,

20.6.3. the Supplier will forward a completed Non-Core Units table (from the ARTP form) to the Treatment Assessment Centre, or such other location advised by ACC, and ACC will negotiate with the Supplier about what price to pay in respect of the Procedure.

21. NO PAYMENT OUTSIDE APPROVAL PROCESS

21.1. Unless Part B clause 18.7 applies, ACC will not pay the Supplier for any Treatment or Post Discharge/Post Procedure Care where Treatment is carried out prior to funding approval or, in respect of a Treatment Injury Procedure, where ACC has not subsequently granted cover for the injury.

21.2. Funding Approval Lapses

21.2.1. Where the Client has not been admitted for treatment within twelve months of the date of ACC's decision to approve funding, the funding approval will lapse. A new ARTP must be submitted to request further approval.

21.2.2. ACC will not pay the Supplier for any Services provided to Clients when Part B clause 21.2 applies unless a new ACC funding approval has been received.

22. PRIORITY CATEGORY TIMEFRAMES AND DEFINITIONS

22.1. Unless Part B clause 18.7 applies, the Supplier will ensure that any recommended Treatment for a Client will be completed within the Priority Category timeframe described in the Client's ARTP measured from the date of ACC's decision to approve funding or such earlier time as ACC may advise, if the Priority Category changes pursuant to Part B clause 22.6 below.

22.1.1. Where Part B Clause 18.7 applies, the Supplier will ensure that any recommended Treatment will be completed within the Priority Category timeframe. This will be measured from the date of the Provider's decision to perform the procedure, to the date Treatment takes place.

22.2. The Supplier must ensure that an ARTP is prioritised 'High" if the Client meets one or more of the criteria specified in clause 7 of the Elective Surgery Services Operational Guidelines at the time of the Client's surgical consultation.

22.3. All clients with approved High Priority ARTPs should receive treatment within 30 days of the date of approval.

22.4. All other ARTPs will be prioritised 'routine.'

22.5. All clients with approved Routine Priority ARTPs should receive treatment within six months of the date of approval.

22.6. ACC Input into "Priority Category" for Treatment

22.6.1. ACC may request a change to the Client's Priority Category if the Client meets, or no longer meets, one or more of the criteria specified in the Elective Surgery Services Operational Guidelines.

22.7. Monitoring of Priority Category Timeframe Requirements

22.7.1. The ability of the Supplier to meet Clinical Priority timeframe requirements is a critical factor in the contract monitoring framework and will be reported upon by ACC from time to time to the Supplier.

22.7.2. Where ACC and the Supplier are unable to agree on a change to the Priority Category following a request by ACC under Part B clause 22.6 above; or the Supplier is not able to meet, or foresees that it may be unable to meet, the Clinical Priority timeframe for a Client or Clients, the Supplier will immediately notify the Recovery Team Member or Treatment Support Team as appropriate responsible for each particular Client.

22.7.3. ACC may, at its sole discretion, either endeavour to agree with the Supplier and the relevant Client an extension of the Clinical Priority timeframe, or, work with Suppliers to make alternative arrangements for the Treatment of the Client, including transferring the client to another Supplier.

23. SIGNIFICANT COMPLICATION TRANSFER OF CARE

23.1. In the event a Client suffers a Significant Complication after Admission, the Supplier will:

23.1.1. Arrange a Significant Complication Transfer of Care;

23.1.2. Report to the Case Manager or Treatment Assessment Centre as appropriate in accordance with Part B clause 23.2; and

23.1.3. Be entitled to charge ACC in accordance with Part B clause 31.7.

23.2. Notification of a Significant Complication Transfer of Care

23.2.1. If a Significant Complication Transfer of Care occurs, the Supplier will, within 2 (two) business days, send a written report to the Case Manager or Treatment Assessment Centre as appropriate, the original Referrer, and the Client's General Practitioner (where the General Practitioner is not the original Referrer) which identifies the Client and describes the Significant Complication and subsequent steps taken by the Supplier (including the Transfer of Care). If the Transfer of Care occurred prior to Discharge, this report will be accompanied by a Notice of Discharge.

24. DISCHARGE INFORMATION – NOTICE OF DISCHARGE

24.1. Purpose

24.1.1. The purpose of a Notice of Discharge is to provide ACC with information on individual Clients, to monitor the completion of Treatment and to provide evidence of appropriate co-ordinated discharge planning.

24.1.2. In the event of staged episodes of Treatment requiring more than one Admission, a Notice of Discharge is required in relation to each discrete surgical episode.

24.2. To Whom

24.2.1. The Notice of Discharge will be sent to ACC at the address specified in the Operational Guidelines.

24.2.2. If required for ongoing client care, relevant information regarding Treatment is to be sent to the original Referrer and the Client's General Practitioner (where the General Practitioner is not the original Referrer).

24.3. Time Limit

24.3.1. A Notice of Discharge is to be received by the recipients listed in Part B clauses 11.2 and 24.2.2 above, within 2 (two) business days of Discharge of each Client.

24.4. Contents

A Notice of Discharge must contain the following information about a Client:

24.4.1. Client name, date of birth and address;

24.4.2. ACC claim number;

24.4.3. Injury diagnosis;

24.4.4. The name of the responsible Named Provider;

24.4.5. Name and MBS-E Code (or replacement code) for the Procedure for which the Client was Admitted as well as any unintended surgery/Procedure or Treatment that was required and/or any special unexpected difficulties or Significant Complication encountered;

24.4.6. Date of Admission;

24.4.7. Date of Discharge or transfer;

24.4.8. Information on arrangements for support, community and Outpatient treatments and follow up consultations; and

24.4.9. The expected date for return to work (including light duties) and/or normal activities of daily living.

25. REFERRAL FOR SUPPORT SERVICES ON DISCHARGE

25.1. Where the Supplier identifies that a Client requires home and community support services after discharge the Supplier will submit a completed Referral for Support Services on Discharge form (ACC705) to ACC as soon as the need is identified. Consideration of Post-Discharge needs will commence at Admission.

26. MANAGE CASE MIX

26.1. The Supplier shall manage its case mix to optimise its efficiencies, subject to complying with the requirements of the Clinical Priority timeframes and other requirements of this Contract.

27. SUFFICIENT RESOURCES

27.1. In any event, the Supplier will take sufficient steps to ensure that, subject to receiving sufficient funding approvals, physical and human resources will be available to complete Services (excluding Implants) across the term of this Contract.

28. OPERATIONAL GUIDELINES

28.1. ACC will publish Operational Guidelines from time to time which will inform the interpretation of the provisions of this Service Schedule, including relevant addresses for submission of forms. The Supplier will provide Services in accordance with the Operational Guidelines but in the event of any conflict between these Guidelines and this Contract, the provisions of this Contract shall apply.

29. PERFORMANCE MEASURES

29.1. The performance measures in Part B, Table 1 below represent initial key service areas that ACC will monitor to help assess service delivery. It is anticipated that the performance measures will evolve over time to reflect collective priorities. Feedback on performance measures will be through the ACC Engagement and Performance network to allow the Supplier the opportunity to address any areas of concern.

Table 1: Performance Measures

Reports	Measures
Volume of ACC surgeries performed by Supplier and number of surgeries performed by body site	Average days by facility and surgeon for High priority surgery to be undertaken; Average days by facility and surgeon for Routine priority surgery to be undertaken

Reports	Measures
Targets	1. 75% of High priority is provided within 30 days of the date of ACC's decision to approve surgery or the decision to proceed with surgery if Part B clause 18.7 applies, and 2. 80% of Routine priority surgery is provided within 6 months of the date of ACC's decision to approve surgery or the decision to proceed with surgery if Part B clause 18.7 applies.

29.2. Where there are factors outside the control of the Supplier which impact on the Supplier's ability to meet the targets identified in Part B, Table 1, then the Supplier and ACC may agree in writing to amend or waive these targets for a specified period.

30. QUALITY IMPROVEMENT AND QUALITY INDICATOR REPORTING REQUIREMENTS

30.1. The Supplier will actively participate as appropriate in sector-wide quality improvement activities, which may be initiated, co-ordinated, and/or monitored by:

30.1.1. The Ministry of Health

30.1.2. The Health Quality and Safety Commission

30.1.3. ACC

30.1.4. Relevant professional associations or bodies, or

30.1.5. Other body with appropriate standing in the sector.

30.2. Reporting

30.2.1. The Supplier will provide a report to ACC on 31 May and 31 October of each year of the term of this Contract describing:

30.2.1.1. their participation in quality improvement activities,

30.2.1.2. the results of such initiatives,

30.2.1.3. the benefits to be expected for ACC clients from these activities, and

30.2.1.4. the results of a Patient Reported Experience Measure (using a tool generally accepted in the sector as being robust) noting changes over time.

31. PRICES, PAYMENT AND INVOICING

31.1. This clause 31 replaces clauses 10.2 to 10.7 of the Standard Terms and Conditions.

31.2. The table in Part A clause 4 contains the Procedures that may be performed under this Contract, and the agreed purchase price for each. ACC agrees to pay the prices set out in Part A Table 1: Service Items and Prices for Procedures provided in accordance with this Contract.

31.3. Any Implant required during a Procedure may be charged for in addition to the purchase price in accordance with Part B clause 33 below.

31.4. The prices set out are the entire amount chargeable to ACC in relation to the Services and no additional amount may be charged to ACC, the Client or other person for Services under this Contract.

31.5. Applicable Price

31.5.1. The Supplier will invoice ACC for Services provided to a Client using the Prices that applied on the Client's Discharge Date following Treatment.

31.6. Prices of Multiple Procedures per Theatre Session

31.6.1. If two Procedures are carried out or are to be carried out during the same theatre session, the total price for all such Procedures will not be the sum of the prices of the respective Procedures shown in Part A clause 4 but will be:

31.6.1.1. the price of the most expensive of the Procedures; plus

31.6.1.2. 40% of the price of each of the other Procedure/s.

31.6.2. If three or more Procedures are carried out or are to be carried out during the same theatre session, the total price for all such Procedures will not be the sum of the prices of the respective Procedures but the Procedures will be deemed to be a Non-Core Procedure and the price will be agreed in accordance with the process set out in clause 18.4. Where a Procedure forms part, or is a subset, of a more comprehensive Procedure, ACC will only pay for the more comprehensive Procedure.

31.7. Significant Complication

31.7.1. At the point of a Significant Complication Transfer of Care (whether internal, or to another supplier), charges to ACC for Treatment will cease.

31.7.2. If, at this point, the Supplier has not completed all Services for a Client, the Supplier shall be entitled to charge a pro-rata proportion of the relevant Procedure price/s. The proportion paid will take into account such factors as the length of time and level of resources committed to the Client. The proportions and prices shall be agreed with the Client's Case Manager or Treatment Assessment Centre as appropriate, or the Treatment Assessment Centre, prior to submitting an invoice.

31.7.3. If agreement cannot be reached within a reasonable period of time including by escalation within each party's organisation, either party can refer the dispute for resolution under the procedures described in clause 19 of the Standard Terms and Conditions.

32. PAYMENTS FOR A TREATMENT INJURY PROCEDURE

32.1. Where funding approval has been given for a Treatment Injury Procedure under Part B clause 18 the price approved for that Treatment Injury Procedure will not be paid by ACC to the Supplier unless ACC subsequently approves the claim for cover for the injury in respect of which the Treatment Injury Procedure was undertaken.

33. IMPLANTS PRICE IN ADDITION TO PROCEDURE PRICE

33.1. ACC will pay the Supplier separately for the cost of surgical implants identified in the ARTP, and the price of such implants is excluded from the prices listed in Part A.

33.2. ACC will pay the Supplier's cost price.

33.3. Documentary evidence of the cost is required if the total cost of the Implant/s used for a Client is $10,000 or greater (excluding GST). Documentary evidence will include but is not limited to the invoice on which the Supplier pays for the Implant/s or the Supplier's agreed schedule of Implant prices

33.4. ACC, at its discretion, may audit the price of any Implants in accordance with this Contract.

33.5. The Supplier will minimise the cost of Implants having regard to issues of quality and performance and when required by ACC shall demonstrate that it has made all reasonable enquiries of the market when required by ACC.

33.6. If ACC enters into supply arrangements directly with vendors of surgical implants, Suppliers will, on reasonable notice by ACC, be required to accept those supply arrangements and use the selected implants unless a sound clinical reason exists, which will be identified on the ARTP.

34. TAX INVOICE

34.1. The Supplier is entitled to raise a separate Tax Invoice for each Client following the completion of the service. To ensure efficient payment processing by ACC, this invoice will contain information consistent with that received in the ACC purchase order which initiated the Service, particularly with regard to service codes.

34.2. The GST invoice will be submitted electronically using one of ACC's prescribed methods (available on the ACC Website). Non-electronic invoices will only be accepted for treatment injury claims.

34.3. The Supplier's invoice will be addressed to ACC and will contain the following details:

34.3.1. The Supplier's name, address and ACC Supplier number;

34.3.2. The GST number of the Supplier;

34.3.3. The words "Tax Invoice" in a prominent place;

34.3.4. An invoice number;

34.3.5. The invoice date;

34.3.6. The relevant ACC purchase order number (unless Part B clause 18.7 applies);

34.3.7. The name of the Contract and the contract number;

34.3.8. The name and claim number of the Client receiving the Service;

34.3.9. The name of Procedure, MBS-E code (or replacement code) and Procedure code for the Procedure (where applicable);

34.3.10. The name of Named Provider(s) delivering the Services and ACC provider registration number;

34.3.11. The name of the facility where surgery was performed;

34.3.12. An itemised list of any unique supplies used, including price; and

34.3.13. The date on which the Service was provided, or if more appropriate, the start and end date, and the length of inpatient stay (where applicable).

34.3.14. The Supplier's invoice may also contain the theatre time for surgical treatment.

35. OPERATION NOTE

35.1. The Supplier will send a copy of the Operation Note for the Procedure with the invoice. The Operation Note will contain all usual details recorded as a matter of good clinical practice including the New Zealand Medical Council number or Dental Council of New Zealand number of the Named Provider, whichever is applicable.

36. TIMEFRAMES FOR INVOICING

36.1. An invoice charging for Services incidental to Treatment and Post Discharge/Post Procedure Care shall be forwarded with or after any Notice of Discharge has been sent to ACC;

36.2. A Significant Complication Transfer of Care invoice shall be forwarded after agreement on the pro-rata Procedure price and with or after the required report/s have been sent to ACC (pursuant to Part B clause 31.7).

36.3. ACC will not pay for a Service where the invoice for that Service is not submitted within twelve months of the date the Service was provided.

37. PAYMENT

37.1. Acceptable invoices received by the 5th of the month will be paid on or before the 20th of the same month. Invoices received after the 5th of the month will be paid the following month.

37.2. Advice of payment will be forwarded under separate cover, detailing the individual invoices that make up the lodgement.

37.3. If any invoices cannot be approved for payment, ACC will advise the Supplier, detailing the reasons why payment cannot be approved, and what steps need to be taken by the Supplier to obtain approval. After these steps have been taken, payment will then be made within 10 business days of approval being given.

38. CONTINUOUS SERVICE IMPROVEMENT AND CO-DESIGN

38.1. ACC is committed to continuously improving the quality of services provided to its clients and to achieving its strategic priorities. ACC will seek opportunities to collaborate with Suppliers to refine service delivery using a process of continuous improvement. The Supplier is expected to:

38.1.1. Work in partnership with ACC in refining its services using a process of continuous improvement;

38.1.2. Collaborate with ACC in any service co-design initiatives either initiated by the Supplier or ACC and agreed by the other party;

38.1.3. Support ACC to identify innovative ways that contribute towards improved service delivery for its clients;

38.1.4. Complete ACCs annual survey of all Suppliers.

39. CLAUSES RELATING TO DISTRICT HEALTH BOARDS

39.1. A District Health Board (DHB) is an entity established under the New Zealand Public Health and Disability Act 2004.

39.2. In respect of Part B any data supplied by the DHB to the Ministry of Health which meets the requirements of this Service Schedule will be deemed to satisfy that requirement, the parties noting that a Memorandum of Understanding exists between the Ministry of Health and ACC to share such data.

39.3. Part B clauses 21 is modified as follows: where the DHB, in the course of managing its public health activities in an efficient manner, fails to gain approval for treatment through the funding approval process described in Part B clause 18 above, ACC may retrospectively consider cover, eligibility and the strength of the case for payment outside the approval process according to procedures and processes published from time to time in the Operational Guidelines relating to this contract.

40. DEFINITIONS AND INTERPRETATION

In this Service Schedule, unless the context otherwise requires:

"ACC Core Procedure List" means the Procedure List made up of ACC's Core and Red List Procedures set out in the Table of Procedure Prices at Part A clause 4 which may be updated from time to time;

"Admission" means the documentation process by which a person becomes resident in a Health Care Facility; and "Admitted" has a corresponding meaning;

"Adverse Event" means an unexpected event which affects the patient's outcome;

"Assessment Report and Treatment Plan" and "ARTP" is the report completed on the template specified by ACC from time to time, available on the ACC Website, required to have been prepared and signed by a Named Provider as a result of an assessment of a Client;

"Care Period" means the period from receipt by the Supplier of a draft ARTP from a referring clinician, or if Part B clause 18.7 applies the Provider notifying the Supplier of the impending procedure, to a date either at which approval is declined by ACC, or treatment terminated by the client, or a date six weeks after the client has been discharged from the facility at which the treatment was delivered.

"Community Services" includes (without limitation) services such as physiotherapy, occupational therapy, speech therapy, orthotics and prosthetics, social work, dietetics, district nursing, personal care, home help and meals on wheels, when those services are provided outside a Health Care Facility setting;

"Discharge" means the process of documentation that changes the admission status of a Client whereby the Client leaves the inpatient or day patient facilities of the supplier having received Treatment;

"Discharge Date" has a corresponding meaning;

"Elective Services" means Personal Health Services which are Services in terms of this Contract, but which are not "Acute Treatment" or "Public Health Acute Services within the meaning of section 6(1) of the AC Act.;

"Equipment for Independence" means a manufactured item that is likely to assist a Client to achieve his or her optimal independence in daily living or which is required by a Client for reasons of safety. Examples include shower stools, crutches, walking frames, wheelchairs, etc;

"Health Care Facility" means a place which may be permanent, temporary or mobile (excluding rest homes, supervised hostels, half-way houses and staff residences) which people attend, or are resident in, for the primary purpose of receiving Personal Health Service;

"Implant" refers to medical and surgical implant devices or biological items that are placed inside or on the surface of the body. They may replace or supplement body parts or functions, deliver medication, or provide support to organs and tissues. They may be permanent or temporary. Examples may include but are not limited to:

- joint replacement prosthesis
- cement and cement restrictors
- plates, screws, wires, staples, pins
- intramedullary rods and nails
- customised implants (e.g. hip, pelvis, skull, TMJ)
- anchors, tapes, fibre-wires, endo-buttons
- mesh: absorbable and non-absorbable
- allografts: bone, tendon, corneas
- bio-absorbable screws and plates
- bio products used to control bleeding or reduce scarring

- other specialised products - Suture wrap, Integra skin
- intrathecal pumps, nerve stimulators, urinary sphincters, cochlear implants
- breast and testicular implants
- implant specific equipment (where applicable and as required).

"Implant specific equipment" refers to specialised, implant specific equipment that is required for either the insertion or removal of the implant. These are normally an integral component of the implant system, are single use items, unique to the implant system and are invoiced as part of the total implants supplier invoice. ACC will currently accept these as part of the implant invoiced costs, and they are not classed as part of normal or unique supply costs. Please refer to the Elective Surgery Operational Guideline for more detailed information of what ACC consider as inclusions and exclusion for implant cost.

"Market Price" means the average agreed price for a particular Procedure of ACC's contracted providers in the relevant Region;

"MBS-E Code" means Medical Benefit Schedule – Extended coding which are procedure codes which relate to the ICD11-AM Diagnostic Codes which is the International Statistical Classification of Diseases and Related Health Problems 11th Revision as set out in Appendix Three. In the context of this contract, reference to MBS-E codes will be assumed to mean reference to any replacement codes if ACC replaces the relevant coding system during the life of this contract.

"Named Provider" means:

1. A Medical Practitioner other than a General Practitioner who holds or is deemed to hold vocational registration and Annual Practicing Certificate granted by the Medical Council of New Zealand that is relevant, or, in the reasonable opinion of a General Practitioner, likely to be relevant, to the injury suffered or apparently suffered by the Client; or
2. an oral surgeon or oral maxillo-facial surgeon vocationally registered with the Dental Council of New Zealand;
3. and who has been identified by the Supplier to ACC pursuant to this contract as a Named Provider to this Supplier.

"Non-Core Procedure" means a Procedure which is not on ACC's Core Procedure List and cannot be fairly and reasonably matched to a Procedure on ACC's Core Procedure List;

"Notice of Discharge" means the notice required under Part B clause 24 to be provided to ACC upon Discharge;

"Operation Note" means the surgeon's record of the procedure performed which is recorded in the patient's hospital file;

"Orthosis" means an addition to any existing bodily segment. Examples include splints, shoulder braces etc; and "Orthoses" has a corresponding meaning;

"Orthotics" means the fitting and fabrication of Orthoses or related technical aids used to support or correct the function of the trunk and upper and lower extremities;

"Outpatient" means a patient who is not admitted but receives treatment, therapy, advice, diagnostic or investigatory procedures or pre-admission assessment at a Health Care Facility and who leaves within three hours of the start of consultation;

"Outpatient Clinic" means a scheduled administrative arrangement enabling Outpatients to receive Outpatient Services at a Health Care Facility (NZHIS Guide 1996/97 p.66);

"Outpatient Services" means Personal Health Services provided to an Outpatient;

"Personal Health Services" means goods, services, and facilities provided to an individual for the purpose of improving or protecting the health of that individual, whether or not they are also provided for another purpose; and includes goods, services, and facilities provided for related or incidental purposes;

"Post Discharge/Post Procedure Care" includes the Services referred to in Part B clause 24.1;

"Priority Category" means the High or Routine category for any recommended Treatment selected by the assessing Named Provider based on the definitions outlined in Part B clause 22 and clause 7 of the Elective Surgery Services Operational Guidelines and recorded in the Client's ARTP; or as deemed by ACC based on the same definitions;

"Procedure" includes a surgical procedure or service which is included in Part A clause 4 or is agreed under Part B clause 18.4;

"Red List" means ACC's list of procedures which ACC categorises under this heading from time to time on the advice of the relevant professional bodies as being relatively low volume/high cost procedures which are undertaken by Named Red List Providers only at specified facilities and which are denoted as Red List procedures in Appendix 2 of the Elective Surgery Services Operational Guidelines. The Table of Procedure Prices is included in Part A clause 4;

"Referrer" means the Medical Practitioner or another provider of Personal Health Services who requests that the Provider provide an Assessment of or medical services for the Client and, if appropriate, Treatment or, where the context otherwise requires, means the Provider who requests that a Medical Practitioner accept a transfer of clinical responsibility for a Client or requests that another provider of Personal Health Services provide an Assessment of or medical services for the Client and, if appropriate, Treatment; and "Referral" and "Referred" have a corresponding meaning;

"Referring Specialist" means the medical specialist who has assessed the client as requiring certain treatment, has completed the draft ARTP and referred the draft ARTP to the Supplier. This party will typically be the Named Provider, but exceptions may occur.

"Resident" means the Client's usual residential address at the date of consultation as set out in the ARTP;

"Routine" means less than six months (but not within seven days of the date the decision was made by the assessing Specialist that the Admission was necessary or the date of Referral for treatment by the assessing Provider);

"Services" has the meaning defined in Part B clause 3;

"Significant Complication Transfer of Care" means the transfer of clinical responsibility for the care and treatment of the Client because of a Significant Complication in connection with the medical condition of the Client to one of the following (whichever is most appropriate for the Client):

- a DHB; or
- a medical, nursing and ancillary team internally within the Supplier, if that complication is within the Supplier's expertise and if the Supplier is publicly funded by the Ministry of Health to provide the necessary care and Treatment as if they were "public health acute services" within the meaning of the AC Act and without charge to the Client or ACC;

"Significant Complication" means a medical complication which arises unexpectedly after Admission and is of such a nature that the Client's clinical priority becomes that of requiring "public health acute services" within the meaning of the AC Act or services or treatment that would be "public health acute services" if provided in a hospital and health service. A Significant Complication is not covered in the Services specified in this Contract. An example of a Significant Complication includes, but is not limited to where a significant medical complication arises unexpectedly, or because of an underlying medical condition that is not related to an ACC claim (for example, a significant asthma attack that has resulted in a pneumothorax, or a myocardial infarction);

“Theatre Time” means the period of elapsed time (in minutes) from the commencement of the anaesthetic (induction) or entry to the Operating Room to the exit from the Operating Room or transfer to Post Anaesthetic Care Unit. This period does not include time waiting in the anaesthetic room or anteroom, nor does it include the time from insertion of a regional block to entry to the Operating Room;

“Treatment” includes the Services referred to in Part B clause 10.2;

“Treatment Injury Procedure” means a Procedure for an injury arising out of medical treatment for which a claim for cover for treatment injury or medical misadventure has been lodged with ACC.